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REPORT No 9

ACHIEVEMENTS IN AST HEALTH SECTOR REFORM IN ARMENIA: AUGUST – DECEMBER 2000

Prepared by

PADCO Armenia Social Transition Program

December 13, 2000

PLANNING AND DEVELOPMENT COLLABORATIVE INTERNATIONAL

Development Solutions for the 21st Century

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ABBREVIATIONS AND TERMS

ARMENIAN ENTITIES AND TERMS

AIHA = American International Health Alliance

AST = Armenia Social Transition Program

AUA-SPH = American University of Armenia, School of Public Health

BBP = Basic Benefits Package

CHI = Compulsory Health Insurance

CHSR = AUA Center for Health Services Research

CSR = Civil Status Registry (records births deaths & marriages, is subordinated to the Ministry of Justice)

CFA = Center for Analysis – in the MOH, issues reports based on administrative reports from health care providers

FBP = Family Benefit Program – administered by the Mergelyan Institute but to be transferred to the MOSS

FHCP = Family Health Care Practice

GOA = Government of Armenia

HIEE= Household Income and Expenditure Survey, conducted annually by the National Statistical Service

IOM = Institute of Medicine at Yerevan State University

JHU = Johns Hopkins University Population Communications Services

MFE = Ministry of Finance and Economy, responsible for developing overall economic policy, ensuring auditing and reporting standards

MOH = Ministry of Health

MOJ = Ministry of Justice, responsible for registering births, deaths and marriages through the CSR

MOSS = Ministry of Social Security

MSR = Ministry of State Revenues, responsible for collecting taxes

NA = National Assembly

NIH = National Institute for Health

Normative acts = Laws of parliament, decrees of the President, ministerial decrees and instructions, that, together, form the legal and regulatory framework for social protection programs

NSS = National Statistics Service

PHC = Primary Health Care

PIN = Personal Identification Number

REL = Republic Employment and Labor Service, responsible for administering unemployment insurance benefits and providing job and training information -- subordinated to the MOSS

RSSC = Regional Social Security Center – there are 52 local RSSCs through which social services are delivered to the population of Armenia

SHA= State Health Agency

SIC = State Insurance Commission

SIF = State Social Insurance Fund, which is administratively independent (but must follow MOSS policy), responsible for collecting payroll contributions and for distributing mandatory insurance benefits including old age, survivor, and disability pensions, and many small social benefits such as childcare benefits to mothers caring for young children, funeral allowances

SRC = Securities Regulatory Commission

STD = Sexually Transmitted Diseases

INTERNATIONAL ENTITIES

IDA = International Development Agency (World Bank)

IMF= International Monetary Fund

SIDA= Swedish International Development Agency

TACIS = Technical Assistance Program for the CIS, administered by the European Union

TNO= Netherlands Organization for Applied Scientific Research

UNDP = United Nations Development Program

UNICEF = United Nations International Children's Education Fund

USAID = United States Agency for International Development

WB = World Bank

WFP = World Food Programme

WHO = The World Health Organization

1. OVERVIEW OF ACHIEVEMENTS

1.1. INTRODUCTION

This report, prepared at the request of USAID, summarizes the achievements in the area of health sector reform of the Armenia Social Transition Program (AST) between the beginning of the program on July 27 and December 13, 2000. The work described is conducted under contract (Number: 111-C-00-00-00114-00). The AST is a complex and comprehensive program based on an unprecedented plan that combines extensive reform in the legal foundation for health and social protection policy with the practical implementation of reforms in the design and delivery of health care and in the delivery of benefits under social insurance and social assistance programs in Armenia. These activities involve the careful sequencing of complex and interrelated tasks.

This report summarizes achievements in fourteen major areas in the health sector. These include seven activities specifically targeted for completion in the first six months of the project in the Award Fee Matrix as well as eight targeted for later completion. The areas discussed, in turn, in the following sections of this report that affect the Award Fee during the first project reporting period are:

- (Task 1A.2) Report completed on worldwide experience on health insurance
- (Task 2A.6) Recommendations for reforms in legal basis of social assistance (including Family Benefits) and health-care programs prepared (65%); adopted by GOA (35%)
- (Task 2A.3) Analysis of institutional structure, options to create single health purchaser completed (50%) and implementation by GOA begun (50%)
- (Task 2A.4) Assessment of out-of-pocket spending on health care completed
- (Task 3A.1) Analysis of existing medical facilities, services, resources in potential pilot sites completed
- (Task 3A.1) Final recommendations for initial pilot site made and staffing completed
- (Task 3A.4) Training program, modules, and materials designed and presented to MOH and Marzes for approval
- (Task 3A.3) Draft of health assessment and health practices analysis instruments to be used for pilot sites presented to MOH, Marz for approval
- (Task 3A.5) Assessment of capacity of regional NGOs

In addition, important steps have been made in the following areas – and are also discussed in this report:

- (Task 1B:T4) Develop automated and manual personified social insurance reporting systems – prerequisite for establishing any health insurance system
- (Task 2C:T1 and T2) MIS assessment for developing licensing and accreditation standards for health care practitioners and facilities
- (Task 1C:T2) Provide support for the implementation of a system for establishing a PIN – a prerequisite for establishing national patient referral system

Each of the following sections describes the tasks undertaken, outlines the major achievements – steps toward building the capacity of GOA counterparts, reports prepared, major meetings held, the opportunities identified by the AST team, the barriers toward further progress in implementing the task, and a brief outline of the further steps that will be undertaken during the first year of the project.

1.2. OVERALL ACHIEVEMENTS

While the following sections describe achievements in greater detail, there are some cross-cutting results achieved during the first five months of the project.

1. The MOH has created and is working through an internal group that is coordinating with project activities. This is used on an "as-needed" basis
2. The MOH has created and is convening regularly a group responsible for designing and managing the implementation of health facility rationalization.
3. The Minister is meeting with AST health specialists with increasing frequency

4. Willing, informed and cooperative local partners have been identified in Vanadzor and in some other local communities. This local capacity promises to enable the AST team to implement comprehensive and successful local pilot projects.
5. The GOA and AST implementing partners are ready and able to begin implementation of some of the complex MIS infrastructure necessary to implement health sector reforms.
6. The AST has linked its activities to Armenia's program to integrate activities to the standards set by the Council of Europe (see attachment to this section).

1.3. OVERALL OPPORTUNITIES

The achievements noted in the previous subsection reflect several opportunities identified by the AST team that will guide future implementation of health sector reform.

1. The breadth of the AST Program allows flexibility and ensures results. Most important among these opportunities is that the breadth of the AST program provides the team with the ability to provide the foundations for comprehensive reform – not simply providing policy advice.
2. Many local agencies and officials in the health sector are ready and informed about the need for and direction of reform.
3. The AST team has identified several well-informed and capable implementing partners – including educational institutions – who will assist in the effective implementation of the project.

1.4. OVERALL BARRIERS

At the same time as identifying opportunities that will enhance the ability of the AST team to fulfill the objectives of health care reform, the team has also encountered barriers that must be overcome to achieve the goals of the project. These barriers are discussed in greater detail in the following sections, as they apply to specific AST program activities. But the most important of these are:

1. Coordination among many donors in the health sector in Armenia is poor. Many important donor programs are conducted by specialists visiting Armenia only intermittently – making regular and timely coordination difficult. The attempt by USAID and the AST team to bring together counterparts and donors in a workshop to improve collaboration proved only partially successful.
2. Many international donors are unable or unwilling to share the goals and approaches of their activities. Many donors are unwilling to share their terms of reference, draft reports, or even to define in detail what approach they are taking. The World Bank, in particular, is involved in many health sector reform activities but has provided few documents that describe its approach to these activities.
3. Many reforms already undertaken in Armenia were poorly designed. The AST team will face a difficult task explaining to counterparts that the reforms already undertaken do not necessarily point in the right direction to create sustainable and efficient systems to implement health care programs – this problem is particularly acute in the areas of sustainable health care financing, the creation of an effective Family Health Care practices, and in the targeting of benefits to the needy.
4. The GOA budget constraints are severe at all levels in the health sector. The primary counterparts in the area of health care reform – SHA, MOH, MOSS and the SIF – lack the money to pay staff adequately, to equip staff with computers, copiers, and access to e-mail, and to undertake other investments that will be necessary to manage health care programs efficiently and effectively, or even to interact with the AST effectively. Therefore, the AST is devoting considerable time to careful assessments of the basic needs of its counterparts and to acquiring the necessary equipment. Within the next two weeks a total of 20 computers and related equipment will be installed in the offices of the primary counterparts to allow them to move forward in planning and developing policy reforms. This is only the first wave in an extensive procurement program that will transform the operations of counterpart agencies as well as the nationwide system of program operation.
5. The structure of the MOH and its relations with health care providers prevents the easy design and implementation of reforms at the national level. With 700 health care facilities and 40,000 physicians, nurses, and administrators, the health care sector is an unmanageable sector. The limits the MOH's ability to manage the current health care sector, much less design and implement reforms, results from its lack of authority over these organizations. MOH also lacks MIS systems that would provide it with the information to exercise what authority it does have. This is an important differ-

ence between the MOH and the MOSS. The latter enjoys much tighter control over the national network of regional social services offices, as well as policy control over the SIF.

6. The MOH lacks depth and equipment to manage large-scale social databases. Health insurance requires the creation of large databases, revenue collection systems, financial management, and benefit distribution systems. The MOH does not have a computer center to create these and to create the capacity would duplicate the capacity already existing in the MOSS and SIF. Therefore, a great deal of the administrative capacity building that will support the reform of health programs will occur in the SIF and MOSS (see especially section 2, 11, and 13 below). Unfortunately, MOH has yet to understand the complementarity between activities supported by the AST in these other agencies and the overall program of health care reform.

1.5. THE NEXT SIX MONTHS

Within the next six months, the AST team is confident that significant steps will have been completed toward building components of the MIS infrastructure that are necessary pre-requisites to the design and implementation of health insurance, improved practitioner and facility licensing, patient caseload referral systems, and health facility management.

The AST is also confident that work in the pilot site in Vanadzor will have already yielded important and tangible results and will be demonstrating the value of an integrated approach to service delivery that combines the resources of the health and the social services sectors.

The AST hopes that the MOH and the inter-agency task forces will have learned some of the managerial skills necessary to implement large, complex tasks in collaboration with international donors.

The AST is concerned about the ability to work closely in collaboration with other donors unless pressure can be brought to those donors by USAID and by counterparts to share information and materials.

ATTACHMENT 1: LINKS OF ACTIVITIES WITH CHARTER OF COUNCIL OF EUROPE

In 1961, The Council of Europe adopted Treaty No. 35, known as the "European Social Charter." The goal of this treaty is to improve the standard of living and to promote the social well being of the populations of member countries. In 2000, Armenia became a member of the Council. The table below shows the actions that will be undertaken by the Armenia Social Transition Program in collaboration with Armenian counterparts in the Government and in the private sector that will further the attainment by Armenia of the goals specified in the European Social Charter.

Article from European Social Charter, Adopted by the Council of Europe	*How Activities Conducted by AST in Collaboration with the MOSS and MOH will Support Armenia in Fulfilling the Goals of the European Social Charter*
11. Everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable	• Rationalizing the use of existing health resources (practitioners and facilities) to provide care more effectively and efficiently • Developing family medicine centers • Training and development of family medicine practitioner professionals to improve the quality of care • Improving licensing procedures for health facilities and health practitioners • Developing of pharmaceutical monitoring system supporting family medicine centers • Creating nationwide patient referral systems to ensure health care practitioners have access to up-to-date medical records of patients
12. All workers and their dependents have the right to social security	• Creating personified reporting system by enterprises to Social Insurance Fund to create records of all Armenians covered by social insurance • Supporting pension reforms to allow increases in benefits to pensioners and invalids • Reforming social insurance benefit distribution system to ensure timely and accurate payments of benefits • Reforming accounting systems and financial projections models for Social Insurance Fund to ensure adequate and timely payment of benefits
13. Anyone without adequate resources has the right to social and medical assistance	• Developing improved targeting mechanisms to ensure access to social and health services to the needy • Supporting reforms in financing systems for health care to ensure adequate funding for the basic benefit package • Creating open and transparent appeals system for people denied benefits by social assistance offices • Developing and distributing to the public information on citizen's rights to social assistance
14. Everyone has the right to benefit from social welfare services	• Reform and automation of the Family Benefit Program • Creation of Monitoring Center within the Ministry of social Security to evaluate effectiveness of targeting benefits on the very needy • In collaboration with the National Statistics Service to develop better measures of family need as the basis for targeting assistance • Creation of open and transparent appeals system for people denied benefits by social assistance offices • Development and public distribution of information on citizen's rights to social assistance • Pilot projects to develop ways to improve access of families to social and health services

Article from European Social Charter, Adopted by the Council of Europe	***How Activities Conducted by AST in Collaboration with the MOSS and MOH will Support Armenia in Fulfilling the Goals of the European Social Charter***
15. Disabled persons have the right to vocational training, rehabilitation and resettlement, whatever the origin and nature of their disability	• Restructuring of Social Insurance Fund to ensure better financing for invalid benefits • Rationalization of health care facilities to improve quality and access to health care services including rehabilitation services • Reform of workers' compensation system to improve services and payment of benefits
16. The family as a fundamental unit of society has the right to appropriate social, legal and economic protection to ensure its full development	• Creation of family medicine services • Strengthening of Employment Services system to provide national listings of job and training opportunities as well as entrepreneurial assistance
17. Mothers and children, irrespective of marital status and family relations, have the right to appropriate social and economic protection	• Improvement of targeting of social assistance and health care services to take into account special needs of women-headed households • Creation of family medicine services

2. REPORT ON WORLDWIDE EXPERIENCE ON HEALTH INSURANCE

2.1. INTRODUCTION

Health insurance is a controversial issue in Armenia. Although the GOA has attempted to push forward a framework law on social insurance that includes a commitment to national health insurance, the government lacks the necessary institutional and financial infrastructure to implement a national health insurance system. The draft law, which had been submitted in the spring, was tabled in early summer, at the request of the World Bank. The AST has prepared a legal analysis of the draft law (and an alternative prepared under the auspices of a USAID contract), which is included as an attachment to this report.

At the same time, the GOA – with support from the Dutch consulting company TNO (financed by the Government of the Netherlands) – has been developing a draft law on Health Insurance. Neither TNO, which is drafting the law, nor the World Bank believes that the financial and institutional situation in Armenia can support the introduction of the law at this time. The AST team concurs with this view. The GOA, lead by the MOH, are, however, still strongly in favor of introducing a draft law within a few months.

The AST has adopted two approaches to the issue of health insurance. It has begun to present the GOA with health insurance options – through issuing a paper describing the experience of other countries in the design and implementation of health insurance systems. At the same time, the AST is assessing the administrative and MIS infrastructure necessary to support any health insurance system that is finally adopted. This involves the creation of a system of personified reporting to the SIF as well as a record keeping system in the SIF (discussed under section 11 of this report). The AST has also begun the process of developing actuarial models and training of actuaries needed to perform the types of financial analyses necessary to support any type of health insurance systems.

Finally, as one of the largest efforts of the AST, the team is supporting the implementation of a PIN system as the basis of administrative record keeping (see section 13 of this report). The work on developing administrative capacity for health insurance has necessarily been concentrated on work with counterparts in MOSS (which is responsible for the implementation of the PIN system and will also manage the GOA's information and analysis center where computerized social protection databases will be integrated), and with the SIF (which will receive the work history and age data on all working Armenians that will support the health insurance administrative database).

2.2. ACHIEVEMENTS IN HEALTH INSURANCE REFORM

The AST can report the following achievements in the area of health insurance reform:

1. Information on health insurance options. The distribution of a paper describing the experience in the design and implementation of health insurance in other countries. This paper was distributed and a seminar delivered by AST short-term consultant Cheryl Wickham on December 4, 2000. The seminar was attended by 40 representatives from MOH, SHA, the National Assembly and the press. A list of attendees is provided in Attachment 1 to this section. A companion report, to be prepared by January 15, 2001, marshals the global lessons toward action steps for health insurance reform in Armenia (outline below)
2. Personified reporting (see section 11 below). A detailed workplan for the implementation of personified reporting to the SIF will be complete by December 31, 2000.
3. Actuarial modeling and skills development. Preparation of a workplan for the development of an actuarial model of the Armenian workforce and the training of actuaries in the MOSS and SIF. This effort was launched with a seminar for future actuaries and policymakers in the social insurance area (including a representative from the State Health Agency) on December 8, 2000, by AST short-term actuarial consultant Mitchell Wiener. A draft paper on the proposed operation of an Office of the Actuary has also been prepared at the request of MOSS and SIF.
4. PIN Implementation. (see Section 13 below)

2.3. OPPORTUNITIES FOR IMPLEMENTING HEALTH INSURANCE REFORM

The achievements noted in the previous subsection reflect several opportunities identified by the AST team that promise the rapid implementation of the new administrative systems required to support health insurance

reform. Most important has been the willingness and speed with which the MOSS and the SIF have been able to respond to the AST team's request to develop collaborative workplans to begin the implementation of the new reporting and record keeping systems that will support social insurance reform across a wide array of programs. All social insurance reform – from health and old-age pensions to unemployment and invalid benefits – will require the creation of the largest single administrative database and supporting management information systems that the GOA will operate. Creating these databases and supporting MIS is a process that will take at least two years – a time period that provides the GOA with the time to consider carefully the type of health insurance that it wants and can afford to provide its citizens.

MOSS and, to a lesser extent, the SIF have designated specialists to staff the new database development and software development systems. These large efforts will be supported by the AST -- with both technical and material support. The World Bank has also collaborated with these counterparts to provide financial assistance in the implementation of personified reporting and database management capacity.

2.4. BARRIERS TO HEALTH INSURANCE REFORM

The AST team has identified three barriers that will have to be addressed in order to move forward effectively in the area of health insurance reform.

1. Failure of collaboration among donors. The leading technical advisors involved in health insurance development – the Dutch consulting firm TNO - has imposed stringent restrictions on MOH working committees on health reform that limit access by the AST to information. For example, MOH specialists are not allowed to share drafts of concept papers or guidelines for reform they have prepared until those papers are approved for public release. TNO considers such drafts proprietary. This limitation on paper flow makes collaboration difficult. AST advisers first met with TNO principals in late September and have since maintained E-mail correspondence with the TNO team leader based in Leiden. In principle, cooperation in technical efforts was pledged during these contacts. Yet, during a 25th October 2000 telephone conference with the AST, the TNO team leader emphatically stated that, under no circumstances, were Dutch-financed working committees within MOH and SHA authorized to circulate any draft to the AST staff until the TNO leader would next arrive in Armenia (12-22 December) at which point he would consider releasing it. In essence, this denies the AST access to the intellectual property of the Armenian health professionals involved in the drafts. Subsequently, AST raised this issue with the Deputy Minister for Health for Personal Health Services, the Chief of the Policy Office and the Director of the State Health Agency all of whom found the TNO position indefensible.
2. Lack of MOH and SHA capacity. The MOH and the SHA lack the internal capacity to develop and manage the management information systems that are necessary to support a national health insurance system. While the MOSS has committed resources to the creation of an Information and Analysis Center that will manage the creation and maintenance of the large databases necessary for social insurance systems, the MOH has an information center in name only. The shrinking of MOH's information center was the result of the marriage and subsequent divorce of the two ministries in 1999-2000 which effectively concentrated all MIS functions to MOSS.
3. Lack of MOH/MOSS understanding. The AST believes that it is not necessary to create duplicative capacity in MOH. Instead, MOH must work closely with MOSS as it develops its plans for a health insurance system to ensure that the MOSS and SIF develop the necessary databases to support whatever health insurance system it decides is appropriate for Armenia. This close collaboration will require not only an information center within MOH but close collaboration between MIS specialists in MOH with specialists from MOSS.

2.5. THE NEXT SIX MONTHS

Within the next six months, the AST team is confident that significant steps will have been completed toward building components of the MIS infrastructure (personification, actuarial model building, and PIN design and implementation) that are necessary pre-requisites to the design and implementation of health insurance. The team will also focus on creating a joint MOH-SHA-MOSS-SIF working group on social insurance reform. This will be necessary if these agencies are to understand that the development and management of social insurance databases is a collaborative effort. Although the systems will be created and managed within MOSS and SIF, they will operate for the benefit of whatever health insurance system is ultimately adopted

and wherever the responsibility of paying benefits to individuals or to health care providers on their behalf. The team proposes to initiate a series of informal seminars on social insurance MIS involving these four agencies in order to build this mutual understanding.

The AST will also pursue further policymaker education programs to strengthen understanding within the GOA of health insurance options.

In January 2001, the AST team has organized a visit by specialists from the Social Insurance Fund of Estonia to describe that country's experience with the design and implementation of health insurance reform.

ATTENDEES AT SEMINAR ON WORLD EXPERIENCE WITH HEALTH INSURANCE

MINISTRY OF HEALTH • Minister Ararat Mkrtchyan • Levon Yepiskoposyan • Nune Mangasaryan • Hovhannes Margaryants • Haik Darpinyan • Haik Grigoryan	**MINISTRY FINANCE AND ECONOMY** • Arkady Khachatryan
STATE HEALTH AGENCY • Ara Ter-Grigoryan • Karlen Antonyan • Karen Avagyan • Khachatur Kolozyan	**MEMBERS OF WORLD BANK-SHA WORKING GROUP ON HEALTH FINANCING** • Movses Aristakesyan • Arsen Davtyan • Ruzanna Pogosyan • Suren Kharazyan • G.Igitghanyan • S.Vardumyan • M.Nazaretyan • H.Kocharyan • L.Harutjunyan • Karen Matirosyan • Tamara Sargsyan
YEREVAN MUNICIPALITY • Nicolay Dalakyan • Vanui Sedrakyan	**ERMED MEDICAL INSURANCE COMPANY** • Tigran Kchachatryan
NATIONAL ASSEMBLY • Ghukas Ulikhanyan • Gagik Aslanyan • Tigran Nersisyan (advisor of Gagik Tadevosyan)	**USAID** • Marshall Fischer • Anna Grigoryan
INTERNEWS • Armine Toukhikian	**AUCON CONSULTING COMPANY** • Artur Grigoryan

ATTACHMENT TO SECTION 2: OUTLINE OF FORTHCOMING AST REPORT "TEN ACTION STEPS TOWARDS THE FORMULATION OF A MANDATORY HEALTH INSURANCE PROGRAM IN ARMENIA"

1. Achieve Political Consensus among Key Stakeholders on CHI Policy Issues
    - Establish ongoing policy dialogue through a series of roundtables and workshops with involvement of MOH, SHA, MOSS, MOF, other government agencies and international donors (USAID, WB, others)
    - Involve in issues-targeted dialogue, as appropriate, a broad spectrum of stakeholders: health care providers, private employers, trade associations, spokespersons from civil society, and the NGO community.
    - Refine outstanding issues on the current conceptual approach (e.g., addressing coverage for the unemployed) and secure a broad consensus on the proposed national approach toward the implementation of CHI.
2. Formulate A National Action Plan
    - Prioritize and assign tasks among the leading stakeholder agencies
    - Designate a "point-person officer" to track each component step of every activity segment
3. Assessment of Perspectives on the Financing Options:
    - Identify tax base for earmarked contributions
    - Incorporate CHI contribution in existing tax burden
    - Set contribution ratio
    - Evaluate potential for additional fund collection
4. Clarify relationships and the fiscal/administrative links between CHI Funds and State Budget
    - CHI replaces vs. contributes to State Budget Health allocations
    - Transfers from State Budget to CHI Fund for non-working population and dependants: ratio, sources, mechanisms
5. Set the Coverage Policy
    - What is the covered population: Eligibility criteria?
    - Insured vs. Beneficiary
    - Address different population groups enrollment mechanisms
6. Benefits Package and Providers
    - Define the set of health benefits to be included in CHI package, based on financial assumptions and expected population coverage
    - Clarify relations to budget-funded BBP
    - Selection criteria for Health Care Providers to be contracted under CHI scheme
7. Management of the System
    - Single CHI Fund vs. Competitive Model
    - Public/Quasi-Public/Private Options
    - Management Information System requirements: PIN, personalized database and registration forms, track of personal financial accounts, computerized national network.
8. Roles and the Place for Private Voluntary Insurance Schemes
    - Eligibility and Coverage

- Relationship to CHI: supplementary to CHI for not-covered benefits and/or not-covered population groups

9. Implementation Timetable and Staging

- Set the implementation policy: immediately vs. a step-by-step method
- Discuss staging options by population group coverage, by geographic regions, by types of medical care (i.e. outpatient vs. inpatient, etc.), by financial contribution rate (to start from lower rate with gradual increase)
- Piloting the new system: yes or no?

10. Elaboration of Legislation

- Based on all above mentioned findings and options, determine the assignment of responsibilities by stakeholder for formulating a package of laws, normative acts and other needed tools for the implementation of a CHI mechanism.

3. RECOMMENDATIONS FOR REFORMS IN LEGAL BASIS OF SOCIAL ASSISTANCE (INCLUDING FAMILY BENEFITS) AND HEALTH CARE PROGRAMS

3.1. INTRODUCTION

Because of the broad array of health issues that will be addressed in the AST Program, the AST team has begun an intensive two-step process to reform and strengthen the legal and regulatory basis for social and health care programs in Armenia. The first step is to analyze the existing structure of laws and regulations. The second step is to identify needed amendments in the existing framework and to begin filling gaps where no laws and regulations exist. The range of laws and normative acts that must be reviewed is very large. In addition, there are many draft laws and draft amendments to existing laws that are being prepared by various Ministries and interministerial working groups as well as by international donors. Therefore, the timetable for the legal analysis has had to be developed that reflects the priorities of both the GOA and the availability of draft material from other international donors and their contractors.

3.2. ACHIEVEMENTS IN REFORMING LEGAL BASIS FOR SOCIAL INSURANCE AND HEALTH PROGRAMS

The AST can report the following achievements in analyzing legal issues related to the health sector and in developing recommendations for reform in social assistance and health care programs:

1. Legal Issues Related to the Organization and Delivery of Health Care Programs (Report distributed to counterparts for comment)
2. Legal Analysis of Two Draft Laws on a Framework for Social Insurance (Report distributed to counterparts for comment)
3. Concept paper on "Protection of Privacy for Government Information Systems" (Report distributed to counterparts for comment)
4. Legal Analysis of Concept Strategy and Concept Law on Pension Reform (Report distributed to counterparts for comment)
5. Analysis of Reporting Requirements of State Health Agency (Report distributed to counterparts for comment)
6. Analysis of Reporting Requirements of Social Insurance Fund (Report distributed to counterparts for comment)
7. Analysis of Reporting Requirements of Ministry of Social Security (Report distributed to counterparts for comment)

3.3. OPPORTUNITIES FOR REFORMING LEGAL BASIS FOR SOCIAL INSURANCE AND HEALTH PROGRAMS

The GOA has been willing in all areas of social insurance reform to reject current drafts and to create new working groups to draft new laws in the five social insurance areas. The AST is supporting the GOA in developing new laws on the implementation of the PIN system, personified reporting, pension reform, and in several other areas.

3.4. BARRIERS TO REFORMS IN LEGAL BASIS FOR SOCIAL ASSISTANCE AND HEALTH CARE PROGRAMS

The AST team has identified two barriers that will have to be addressed in order to move forward effectively in the area of health insurance reform.

1. Failure of collaboration among donors. The major donors involved in social and health sector reform has been unwilling or unable to collaborate with the AST team.
2. Lack of MOH and SHA capacity. The MOH and the SHA lack the internal capacity to develop and manage the health reform process. They are unfamiliar with many of the complex issues that must be addressed with the drafting of the necessary normative acts.

3.5. THE NEXT SIX MONTHS

Within the next six months, the AST team is confident that significant steps will be taken to develop concrete proposals for the implementation of the PIN system, a privacy protection law and pension reform. The foundation for reforms in invalid benefits and workers compensation reforms will also have been established. Progress in the area of health insurance and several other areas should be delayed until the counterparts have developed a clearer vision of what is needed to implement reform

Nevertheless, many of the institutional and MIS foundations for reforms in these areas will have been laid – providing the AST team and the GOA with better information and the capacity to move forward with reforms more effectively.

4. ANALYSIS OF INSTITUTIONAL STRUCTURE AND OPTIONS TO CREATE SINGLE PURCHASER OF HEALTH CARE SERVICES

4.1. INTRODUCTION

The MOH began developing options for health finance reform in 1997. Working groups on health finance, supported by World Bank loan funds, examined the following issues:

- Financial analysis of the Basic Benefits Package, a defined set of services entitlements for recipients of State-financed diagnostic and curative services.
- Evaluation of options for mandatory health insurance developing several versions of a Concept Paper (final version approved by Government in mid-2000 and a draft Law scheduled for presentation to the National Assembly during 2001).

The MOH, with advice from the World Bank and TNO, created the State Health Agency in 1999 to separate provider payments from the management of health care delivery. This effectively precludes creating any new health finance mechanism *de novo*. Sub-offices of the SHA were established in most Marzes to verify and process claims for reimbursements for authorized services. The SHA may be regarded as the framework into which it would be possible to insert the proposed State Medical Insurance Agency if mandatory health insurance were to be enacted. One year prior to the AST, the GOA accepted bilateral assistance from the Dutch Government (brokered by the World Bank).

The MOH and SHA are proposing to introduce in the Health Budget Law provisions for FY 2001 a risk-pooling quasi-private insurance system, known as "Open Enrollment." This is similar to systems promoted by major insurance carriers in industrialized countries. Care providers would actively solicit client families or individuals who must "sign up" with the provider for services. The purpose is to encourage local health providers to demonstrate a business-like approach to offering high quality services. This approach has proven, outside Armenia, to encourage providers to improve their standards of health services for a "fair market" price -- if not a competitively determined one.

4.2. ACHIEVEMENTS IN ANALYSIS OF SINGLE HEALTH CARE PURCHASER OF HEALTH CARE SERVICES

In the area of health care financing reform, the AST can report the following achievements:

- Seminar on "Comparative Experience on National Health Insurance Systems: Selected Review of International Experiences" (see Section 2 of this report);
- Health Care Background paper No. 2 entitled "How to Pay for Primary Health Care Providers in Armenia," drawing on the AST team's experience with alternate financing of basic health services in Central Asian Republics (included at the end of this section);
- Weekly working sessions with leadership and consultants of the SHA to identify priority research topics;
- Five meetings with staff of the Dutch consultancy, TNO on their advice to the GOA on drafting a health insurance law and assessing the GOA's readiness to implement health insurance;
- Frequent contact with key members of the financing-oriented working groups (especially Hovannes Margaryans, Adviser to the Health Minister, and Movses Aristekesyan, Chair of the World Bank-led committee on financing) to provide technical literature, analytic pieces, legal statutes, and normative acts; and
- Active participation by the leading adviser on health financing options, M. Aristekesyan, in PADCO's seminar on "Developing Actuarial Skills in Armenia."

4.3. OPPORTUNITIES FOR CREATION OF SINGLE HEALTH CARE PURCHASER OF HEALTH CARE SERVICES

The achievements noted above build the foundation for future work in the health finance area. The AST is confident that its specialists in health finance from the USA, Kazakhstan (which first built a mandatory health insurance program based on a single purchaser), Kyrgyzstan, and Ukraine can provide Armenian

counterparts with a broad range of options and the technical expertise to choose among these options for a system best suited to Armenia's special needs.

4.4. BARRIERS TO CREATION OF SINGLE HEALTH CARE PURCHASER OF HEALTH CARE SERVICES

Institutional resistance to sharing information by donors (see Section 2 above) has delayed fact-gathering and analytic work of the AST team. In the three years prior to AST team's arrival, other donors – including the World Bank and Dutch Advisors -- have a large body of research and policy recommendations that are closed to the AST. TNO, for example, has strongly supported proposals for the reorganization of the health sector, especially:

- Concept Paper on a Compulsory Medical Insurance Law
- Drafting of Legislation for the Compulsory Medical Insurance Organization
- Health Financing Modeling, including options for co-payments
- Determination of Packages of health Services benefits (Annual review of SHA's BBP)
- Institutional strengthening of the Preferred Provider Agency
- Conceptual Work on the Optimization of excess capacity in health facilities and human resources
- Advisory Work on the Selective contracting of provider organizations
- Initial technical support for Quality Assurance Work
- Approaches to a more flexible categorization of State Order budget transfers among approved and more generalized line items. (Item was reviewed at 18.10.00 AST "Kick-Off Caucus")

This lead has influenced the thinking of counterparts but TNO has not shared information that describes their recommendations so that the AST can identify the direction of the advice of these advisors. During 1998-2000, World Bank-financed experts, both Armenian and ex-patriate, assessed key aspects of governance for many GOA ministries and agencies. The MOH was the focus of detailed assessments, with analyses conducted of the conduct of management functions, planning and human resources development, forecasting and budgeting. The SHA was also singled out for managerial analysis. In October 2000, the World Bank provided USAID the "Executive Summary" of this Governance study. This included several important findings about MOH and SHA management practices. The AST's requests to the WB for copies of the study have, so far, been rejected. on the grounds that the document is still under internal review. The WB has also refused to provide AST staff with the names of Armenian specialists who contributed to the study -- denying the AST team information from knowledgeable counterparts.

Similarly, the AST team has been denied access to draft technical documents prepared by MOH and in Shirak Marz by TNO-supported working groups (see Section 2 above). TNO restricts discussion and circulation of written products from the work groups on optimization.

4.5. THE NEXT SIX MONTHS

The AST team's approach to the next six months on health finance issues will include the following elements. Negotiations to identify areas where AST may begin work in the health finance area. Some progress has been made with the WB working group on health finance and with TNO. The most likely areas for immediate AST involvement are:

- Seminars, workshops, and written reports linking pilot project activities on lessons learned from international experience with financing options for mandatory health insurance. An AST Report to be completed in January 2001 sets the agenda for these action-oriented lessons. The outline of the report is presented in an attachment to Section 2 of this report.
- Development of financial analysis capacity – including actuarial analysis and unit cost accounting for health care services. A weakness of previous technical assistance provided by the WB and TNO is the failure to develop adequate financial analyses of health care options.

ATTACHMENT TO SECTION 4: HOW TO PAY FOR PRIMARY HEATH CARE

1. BACKGROUND

Armenia is beginning to restructure its health care system. The new system will serve the needs of the population through Primary Health Care Centers (PHC) rather than specialized health care facilities. Under the new system, patients will first seek medical care at their local primary care provider where family care physicians will offer outpatient health services. These physicians treat all members of the family -- men and women, the elderly as well as children. Experience in other countries shows that properly trained family care physicians can treat approximately 85-90% of all health conditions. Since this type of primary health care is much cheaper to provide than treatment in specialized inpatient clinics and hospitals, this restructuring makes good quality health care affordable for Armenia.

But some people require specialized assistance. These patients are referred to medical specialists located in larger medical facilities. An important role of the primary care providers, therefore, is to decide which patients should be referred to inpatient hospitals, specialists, and diagnostic facilities and which patients can be treated in primary care.

2. FUNDING PRIMARY HEALTH CARE PROVIDERS

This new emphasis on "screening" patient needs through Primary Health Care Centers will require a new way to pay for health care. The way in which the primary care providers are financed in many other countries is through a mechanism called "fundholding." This mechanism involves the setting, at the national level, what is called a "capitated rate." This rate setting policy establishes for every eligible citizen a rate of, for example, 46,000 drams per year for health care services. Citizens are encouraged – through an intensive public education campaign -- to enroll in the family practice of their choice. Since it is important that citizens are able to choose among different Primary Health Care Centers, it is important that these new centers be established throughout the nation. When citizens enroll in their chosen Center, that center is allocated an amount of money equal to the "capitated rate." If 5,200 people enroll in one family practice unit, the family practice unit would have a budget of 239 million drams per year with which to pay for all health services of their service population during the year [5,400 x 46,000 = 239,200,000]. All the salaries and operating costs of the family practice unit must be paid from this budget.

When the Primary Health Care Center cannot treat a patient's condition, the patient is referred to a specialist, a diagnostic facility, or an inpatient facility. The cost of specialist services, diagnostic procedures, and/or hospital services is paid by the Primary Health Care Centers to the specialist provider. Therefore, if the salaries and operating expenses of the Primary Health Care Center add up to half of the Center's budget of 239 million drams, the payments for services provided by specialists, hospitals, and diagnostic facilities are paid from the other half of the Center's budget.

This financing system helps to meet several important goals:

1. It develops competition among PHCPs to attract people to enroll for health care by offering innovative services and by establishing a record for high quality medical care.
2. It leads to the public being better informed about the structure and benefits of primary care/family medicine.
3. It provides a mechanism in which the people in the community and competing PHCPs define health care needs, rather than those needs being defined by policy makers in the nation's capital.
4. It places control of health care financing in the hands of the health care providers -- who are closest to their patients and more familiar with local needs.
5. It encourages competition among specialists, diagnostic facilities, and hospitals for referrals – again by offering better quality care at more reasonable prices.
6. Health care providers at all levels will develop pricing systems for services that reflect actual costs based on best health care practices and best management.

Changes of this magnitude will require changes in all parts of the health sector. Because PHCPs are encouraged to treat rather than refer patients, the Government of Armenia will have to develop modern treatment

standards and quality assurance mechanisms. At the same time, the emphasis on physicians who are more versatile and flexible in their skills will require new training curricula in medical schools t colleges to create the new experts in family medicine.

5. ASSESSMENT OF OUT-OF-POCKET HEALTH CARE SPENDING

5.1. INTRODUCTION

Out-of-pocket payments from patients to care providers (in cash and in-kind payments to doctors) are widespread in Armenia, as in other FSU countries. In the absence of regular wages from their health facility, physicians regard such payments as necessary for the continued provision of health care. Physicians do not necessarily pressure patients for informal payments and do not necessarily deny service to patients who are unable or unwilling to pay.

First attempts to address out-of-pocket payments were made in the 1990s under the Health Financing Reform component of the WB loan. But many public health care administrators find it difficult to discuss the subject openly. Accepting informal payments is, after all, illegal. Reluctance results from:

- Unwillingness to disclose informal income because disclosure would be incriminating.
- If a provider were to publicly announce "prices", competing providers, eager to attract patients adjust their prices to attract patients.

Those obstacles must be taken into account when collecting data on out-of-pocket payments. It may be possible to collect better estimates through surveys of paying patients – an option that will be explored through the PADCO survey of households (see Section 14, below). The AST will also conduct an "expert opinion" evaluation. This was first used in documenting Armenia's health sector revenues. In 1996, a local experts' task force analyzed – with TNO support -- data and estimated figures from several financial databases, including:

- Total number of patients treated in hospitals in 1995,
- Estimates of a realistic daily rate for hospital treatment,
- Estimates drawn from the average length of stay in hospitals,
- Funds disbursed from the state budget for health sector's needs
- Data on estimated volume of medicines and supplies received from international donors in the form of humanitarian assistance.

The findings, based on 1995-1996 expenditure data, were:

- 25 % of known expenditures for health were paid from the State budget,
- 15% was imputed as coming from humanitarian assistance, subsidizing providers and operating costs.
- 60% was imputed as coming from out-of-pocket payment1

The estimated error margin for this assessment was 10-15%.

5.2. ACHIEVEMENTS

1. The AST has begun a program of collaboration with the National Statistics Service (NSS) to improve the annually collected "Household Income and Expenditure Survey" (HIE). The questionnaire includes questions about expenditures – informal as well as formal – for health care services. This will provide the best source of information about health care expenditures for different categories of the population.
2. The PADCO Survey of 1,000 families on use of and attitudes toward health and social services may include questions on informal payments for health care in future surveys (see Section 14, below)
3. As archival documentation is poorly practiced in most if not all public sector settings in Armenia, the AST team considers it an achievement to have identified the sources for the publicized estimates of the ratio of state revenues to out-of-pocket payments for health care expenditures. By persistent interviewing and questioning with counterparts and technical advisors both in and outside of Armenia, AST staff identified a core Armenian professional who formulated the methodology and made the

[1] As defined by the expert group, out-of-pocket payments folded into the calculation both cash as well as a fair estimate of the actual value of in-kind gifts to providers, as well as expenditures on medicine, supplies, food and other items

calculations in 1996-1997. Original documentation of the 1996-1997 calculations, prepared in Armenian, is currently being translated into English for use by the AST team and TNO colleagues.

4. Discussions with health finance specialists researching data on out-of-pocket expenditures led to analysis of the security of financial and patient treatment data.

5.3. OPPORTUNITIES FOR COLLECTING BETTER DATA ON INFORMAL PAYMENTS

The NSS has proved a willing and competent partner in the area of HIE reform. This will provide, if implemented regularly, reliable data on household spending for health care.

In addition, the AST has been able to implement the baseline survey of 1,000 households quickly and effectively through survey experts at Yerevan State University. The follow up surveys will provide the AST with the opportunity to ask the 1,000 household panel specific questions about formal and informal health care spending.

Finally, the AST team is beginning a series of detailed accounting analyses of health care providers in the pilot sites in Lori Marz.

5.4. BARRIERS TO COLLECTING BETTER DATA ON INFORMAL PAYMENTS

Experts with whom the AST has held meetings stated that any estimates of informal payments will be unreliable. Although the SHA collects data from 700 provider facilities, SHA lacks the MIS capacity to analyze the data it maintains.

5.5. THE NEXT SIX MONTHS

The AST team will implement its program of collaboration with the NSS – beginning in December 2000. It will also implement the financial audits of health care facilities to provide a basis for estimating – by imputation – the potential role of informal payments,. Further, in the design of follow-up surveys to the PADCO baseline survey implemented in December 2000 – the issue of informal payments for health care will be a primary concern.

It is unlikely that health care reform will eliminate out-of-pocket payments – such payments are too strongly rooted in Armenian culture and history. But restructuring financial and reporting system will reduce the importance of such payments and will expand access by low-income families. The AST believes that reforms in health care financing will begin the slow process of "phasing out" under the table payments by:

- building economically sound official payment systems in hospitals with transparent prices and revenue distribution systems (as has been implemented successfully in Nork Marash Medical Center);
- ensuring on-time and proper payments from the state budget to medical facilities;
- increasing salaries of medical staff, utilizing additional income sources from official paid services; and
- strengthening hospitals' financial management and optimizing human resources.

6. ANALYSIS OF EXISTING MEDICAL FACILITIES, SERVICES, AND RESOURCES IN POTENTIAL PILOT SITES

Discussed in the following section.

7. FINAL RECOMMENDATIONS FOR INITIAL PILOT SITE

7.1. INTRODUCTION

A major piece of the strategy agreed upon in the AST contract is to create models for reform through the identification and development of pilot project areas. In the original contract, it was foreseen that as many as 5 pilot project areas would be selected including a pilot site in Yerevan City. Pilot project selection criteria, [pre-operational and on-site selection criteria], have been developed based upon factors of feasibility, replicability, and sustainability [See Attachment]. These criteria have been applied, thus far, to Shirak and Lori Marzes and, following site visits, will also be applied to Syunik Marz.

An additional selection criteria, specific to the context of the AST Project, is that there be broad acceptance and established feasibility for the integration of health sector and social sector reforms within the selected Marz.

In furtherance of the above strategy, four visits were made to Vanadzor, Lori Marz from November 14 through December 6. The purposes of the visits were to meet the Head of the Marz Department of Health and the Marzpet to ascertain the level of interest in reforms, the number of specific actions that have already been taken towards optimization and reforms, the foreseeable obstacles to reform, the geographical and administrative delimitation of the pilot area that is both feasible and valid for replicability, and the linkages between Ministry of Health and Ministry of Social Security structures and functions that will increase the efficiency of operations and convenience to the beneficiaries.

7.2. ACHIEVEMENTS IN DEVELOPING FINAL RECOMMENDATIONS FOR INITIAL PILOT SITE

1. Lori Marz has satisfactorily met all the pre-operational pilot project selection criteria;
2. Permission was given by the Marzpet and the Head of the Marz Department of Health to undertake a complete analysis of the financial systems, status, and procedures. A local firm has been identified and contractual terms have been negotiated to begin work in January 2001 [see Attachment];
3. Permission was also given by the Marz Health Department and the Marzpet to carry out a complete mapping of all Marz health facilities, personnel, and equipment. Included in this assessment will be a complete description of services provided by facility. A qualified local organization has been identified and initial negotiations begun to begin this work in January 2001 [see Attachment];
4. A Lori Marz Reform Task Group numbering 12 members was formed that represent each of the major stakeholders in the Marz: it includes representatives from MOH (who will manage the working group), MOSS, local NGO's, Marz Administration, the education sector, the Nurses' Association, Labor Unions, and private industry (see below);
5. The Marz Health Department, with the approval of the Marzpet, has allocated office and training space on the second floor of Polyclinic No. 2. These spaces are free-of-charge and constitute a local in-kind contribution; and
6. A pilot project manager has been recruited, interviewed, and selected for placement in Vanadzor in mid-January, 2001

7.3. OPPORTUNITIES IN DEVELOPING FINAL RECOMMENDATIONS FOR INITIAL PILOT SITE

The achievements listed above have been realized in an unusually short period of time. This bodes well for rapid implementation of the optimization of health care facilities and staff by the MOH and also the subsequent restructuring of the health care delivery and financial systems required to establish family medicine as the provider of Primary Health Care throughout the Marz.

The level of cooperation to date from the Marz authorities and the Marz Health Department has been very high. The thoroughness and seriousness with which the initiatives of the AST Team have been treated is a clear indication of how the efforts of the team will be dealt with in future.

During the course of seven visits over the last month to Lori Marz by AST Team members dealing with both health care initiatives and work in the social sector, there have been a large number of spontaneous expressions of interest and high motivation among ordinary citizens regarding the contemplated reforms in both the health and social services sectors.

The high potential for developing an integrated approach to health service and social service delivery is clear in that the AST teams dealing with both sectors have met with acceptance on all sides.

7.4. BARRIERS TO DEVELOPING FINAL RECOMMENDATIONS FOR INITIAL PILOT SITE

The AST team has identified some barriers that need to be addressed in order to make forward progress in the reforms.

1. Resistance within the Marz Health Care System and Marz Administration. The broad-based, twelve member Task Group that has been established in Vanadzor was set up for the purpose of providing inputs into the optimization process initially and throughout the course of reforms in the health care system and social welfare system. It was recognized that the ultimate decisions, especially regarding optimization, would remain in the hands of the top echelons of the MOH in Yerevan
2. The scope of the MOH Optimization, as differentiated from the reforms to be tested in Lori Marz, needs to be clearly defined.
3. The AST Project lacks the resources to undertake reforms throughout all of Lori Marz if those reforms were to include renovation and equipping of Family Practice facilities and provision of computers to health facilities. For that reason, the optimization, which is seen as being part of the restructuring of the health care service delivery and financial support systems, was also being restricted to Vanadzor City. The MOH in Yerevan expressed disappointment with AST's plan to only carry out the pre-Optimization assessments and analyses in Vanadzor City and, by implication, has requested that these assessments and analyses include all Marz health facilities and personnel.
4. Absence of a clearly defined approach and strategy for the development of PHC. Although moves have been made to define and legalize Family Practice as a specialty and two different approaches have been developed to train Family Practitioners, a strategy and approach are lacking with regard to how family practitioners will be integrated into the larger health care delivery system, how they will be financed, how they will acquire the clinical training they now lack, and how to develop the means of providing PHC between today and the time when there will be adequate numbers of adequately trained family practitioners to fully staff a nationwide primary health care system.
5. A history within the USAID/Armenia Mission and the Yerevan MOH of less than positive experience with the current Head of the Marz Department of Health. The major counterparts for the AST Project in Lori Marz are the Head of the Marz Department of Health and the Lori Marz Marzpet. The MOH Yerevan has expressed doubts about the strength of the Marz Head of the Health Department and the USAID Armenia Mission has had a succession of issues with this individual over the last two years that place in question his reliability as a trusted counterpart. This will have to be dealt with through the MOH Yerevan because it is only they who can suggest an alternative counterpart or alternative way for AST to work within the Marz.

7.5. NEXT SIX MONTHS

Given the rapidity with which steps have been taken in Lori Marz, there is good reason to believe that future progress in developing the pilot site will also be rapid. Over the next six months, it is anticipated that the AST office and training facility will be established, equipped, and staffed. The assessments of financial status and procedures as well as health care facilities and personnel should be completed within the next three months. The initial steps in the Pilot Project Implementation Plan will have been taken including the coverage mapping on access to service populations and the preliminary steps in the design and development of the Management Information System and Health Information System will have been completed.

PROPOSED LIST OF THE LORI MARZ REFORM TASK GROUP

Name	*Position*	*Profession*
TBD, Director of Working Group	Nominee of MOH	
Yuri Bablumyan	Head, Lori Marz Health Department	Health Care Manager
Siranush Grigoryan	Accountant, Hospital #2 Vanadzor	Finance & Accounting Specialist
Marine Chatinyan	Senior Specialist, Vanadzor Marzpetaran	Economist
Anahit Hakobyan	Teacher, School #3, Vanadzor City	Educator and Information Specialist
Taron Stepanyan	Engineer in Vanadzor, Marzpetaran	Engineer in State and private enterprises
Koryun Shekolyan	Chairman of NGO Aragast Social Agency	Manager in NGO Sector
Verdan Abovyan	Labor Union Rep., Anesthesiologist at Vanadzor Maternity	Physician and Labor Union Representative
Silva	Physician, Polyclinic #2, Vanadzor	Head Physician, Poly. #2 and PHC specialist
Varsik Petrosyan	Lori Marz Chief Nurse	Nursing
Anna Hakobyan	Administrative Asst. Lori Marzpetaran	Secretary, Administrator
Tigran Papanyan	Head of the Lori Marz Soc. Sec. Office	Manager of Marz Social Security System
Arthur Melkonyan	AIHA Representative	Observer & coordinator

This is a tentative list of Lori Marz Reform Task Group members. This list will likely be significantly altered by the MOH, Yerevan. The functions of the group are purely advisory and they have no decision-making power.

8. DESIGN AND PRESENTATION OF FAMILY HEALTH CARE PRACTICE TRAINING

8.1. INTRODUCTION

The task of designing or revising a curriculum for Family Health Care Practice (FHCP) in Armenia is closely intertwined with AST activities on optimization. In brief, it is anticipated that the optimization of the health system in Armenia will result in the closure or consolidation of numerous health facilities and the reduction or reassignment of substantial numbers of health care workers. Family Health Care Practice—with its clear definition of the role of Family Health Care Providers as being the providers of most health care services as well as the controllers of the majority of health care funds—is envisioned to be the new model on which the optimized Armenian health system is based.

Prior to the initiation of AST activities, the MOH had already taken substantial steps in the area of FHCP. These initiatives are described below.

8.1.1. Background on PHC / FHCP reform initiatives in Armenia financed by World Bank loans

The Ministry of Health began to pursue improvements to the delivery of PHC services in 1997, funding these improvements through an earmarked portion (40%) of the ten million dollar loan-cum-credit provided by the World Bank (WB) for health sector reform. Health sector leaders selected the FHCP model as the most appropriate framework to carry out the reform of basic health care in Armenia. It was realized that provision would need to be made for the post-graduate education of selected physicians and nurses in FHCP. These educational efforts followed two complementary yet separate tracks: 1) a nine-month retraining of pediatricians and general interns to become Family Health Care Practitioners (conducted by the National Institutes of Health (NIH)) and 2) a two-year residency program at the Yerevan State University Institute of Medicine (IOM) in Family Medicine.

Training participants in the NIH program are trained in clinical assessment, treatment and patient-provider communications skills. This training was designed to enable participant providers to work within a team based at a common site and to deliver basic medical services to defined population groups (adults, children, pregnant women). The training program is complemented by the use of the loan funds to rehabilitate rural ambulatory clinics as Family Medicine delivery points and to equip them with a defined set of medical equipment for diagnosis, examination and treatment. Personnel on the WB-funded project estimate that approximately $50,000 of expenses are incurred in the renovation and equipping of each ambulatory. The purchase price of an ambulance for each participating ambulatory clinic is also included in this cost.

Residents in the IOM program are trained according to an adaptation of a standard approach to FHCP. Residents receive a stipend funded by the World Bank loan. Employment possibilities for graduates of this program do not appear to have been clearly thought through.

8.1.2. AST scope of work for this task

USAID contracted the implementers of the AST to design a training program and materials for family medical practitioners within the first six months of AST project activities. As is noted below, existing efforts in this regard by two separate arms of the Armenian health services required the AST team to seek an innovative alternate approach to this task. Achievements, opportunities, barriers, and planned future activities related to this task are described below.

8.2. ACHIEVEMENTS

1. Researched and translated into English the content of the current draft versions of the two principal FHCP curricula in use in the Republic of Armenia. Formal contacts were initiated with the two Chairpersons of the Departments involved in the training of Armenian health personnel as Family Health Care Practitioners: Dr. Samvel Hovhanissian of the Department of Family Medicine at the NIH and Dr. Mikayel Narimanyan of the Department of Family Medicine at the Institute of Medicine, Yerevan State University. Armenian language versions of the curriculum used in these two programs were obtained and translated into English.

2. Critique of curricula currently used for training FHCP personnel in the Republic of Armenia. The AST commissioned a private critique of the FHCP curricula for physicians used by the NIH and the Institute of Medicine at Yerevan State University. This critique (see Appendix 1 for this chapter) was conduced by a published authority (an Armenian-American U.S. physician with extensive involvement in the field of primary care in Armenia). These curricula were also critiqued by experts in FHCP training programs on the AST team.
3. Initiation of work sessions at the YSU Institute of Medicine Program in Family Medicine. A series of work sessions were held with Dr. Narimanyan (the Chair of the Department of Family Medicine at the IOM). The primary topics that were explored during these work sessions were 1) options for integrating graduates of the IOM Family Medicine program into the existing primary health care system and 2) opportunities to enhance and extend the clinical practice opportunities available to students currently enrolled in the IOM Family Medicine program.
4. Discussion with residents currently enrolled in the YSU Institute of Medicine Program in Family Medicine. A discussion was held with first- and second-year residents in the IOM Program in Family Medicine regarding their expectations and future roles in the field of Family Health Care Practice.

8.3. OPPORTUNITIES

1. Collaboration with the Department of Family Medicine at the Institute of Medicine. The Department of Family Medicine at the IOM comprises the long-term future of FHCP in Armenia. The Chair of the Department, Dr. Mikayel Narimanyan, is a dynamic individual who is open to ways to improve ongoing activities. Dr. Narimanyan is in search of a role for graduates of his program in the provision of primary care services in Armenia. A coordinated effort to support the establishment of a Family Health Care Practice clinic in central Yerevan would serve to model a sustainable, affordable version of primary care staffed by graduates of the IOM Family Medicine program. Such an effort would also provide a practice site for residents currently enrolled in this program. The curriculum could be strengthened by the formal use of a preceptor model, whereby existing general and narrow specialists work with IOM Family Medicine graduates and current residents to strengthen their clinical skills.
2. Assisting the Ministry of Health develop a plan for the long-term rollout of FHCP based on revised training curricula. In meetings with AST team members, MOH officials have been unable to verbalize a plan that clearly states how a health system based on a FHCP model will be achieved. The MOH does not appear to have a clear vision of how graduates of the IOM Family Medicine training program will be placed in clinical sites. The future of the NIH retraining program is likewise unclear following the cessation of funding from the World Bank loan in 2001. Substantial opportunities exist for the AST to assist the MOH in the development of a long-term plan for the realization of a FHCP model, based on revised curricula (and training sites) that emphasize clinical practice-based training in sites similar to the training participants' posts. Extant curricula successfully piloted in other countries of the Former Soviet Union under the Zdrav Reform Program will serve as models to compare curricula currently in use in Armenia.
3. Reallocation of World Bank resources. The funding model for the seventy ambulatory clinics that are being renovated and re-equipped under the program funded by the WB loan is extremely costly. The amount of funds spent on the average ambulatory is fifty times greater than those that were found to be necessary to adequately renovate and re-equip ambulatory FHCP units under a USAID-funded health sector reform project in Kyrgyztan. Funds may be able to be conserved by reducing the renovation/re-equipping costs of the ambulatories that have yet to be completed. Savings could then be used to fund a much broader and more sustainable equipping of FHCP units across the Republic.

8.4. BARRIERS

1. Inappropriately stated task: The task of designing a training program and materials for FHCP as stated in the original proposal was inappropriate given significant previous efforts to develop curricula by the NIH and the IOM. The AST team quickly realized that this task would need to be substantially revised in order not to be redundant with respect to existing efforts. Inefficiencies in project implementation have been encountered due to the unforeseen need to redefine this task.

2. Lack of cooperation from key players in the field of FHCP. Although the AST team has forged strong working relationships with individuals and organizations (such as Dr. Narimanyan of IOM, MOH, and the Yerevan Municipality), others have not welcomed the AST. For example, efforts to obtain key documents such as the NIH Family Medicine curriculum have been blocked.
3. Centralization of training: Centralized training allows the development of unified training curricula. Training for family medicine practitioners in Armenia is currently conducted in Yerevan -- typical of the centralized Armenian health service. But it threatens the effectiveness of the training especially for rural practitioners. What is learned in a well-equipped urban setting -- where many different treatment options are available -- is not applicable in rural settings. Those trained in urban settings quickly become acclimatized to "city medicine", leading to feelings that their training cannot be applied in their rural or small-town practice. The tendency of Armenian medical educators to lecture in city-based classrooms, rather than teaching through demonstration and practice in appropriate clinical settings, is a barrier to the development of appropriate techniques.

8.5. THE NEXT SIX MONTHS

The next six months will be a challenging and innovative period for this aspect of the AST. If the AST is to take concrete, well-considered, steps to support curriculum development, AST specialists must work with the MOH to define a long-term plan of how FHCP will become the basis for providing health care. This requires defining the respective roles of NIH and IOM Family Medicine training programs in training Family Health Care Practitioners and deciding how the AST can support and strengthen this training.

AST's support of Family Medicine curricula goes hand-in-hand with strengthening the clinical aspects of training for care providers. In the next six months, AST specialists must work with counterparts in health services to develop models of clinical practices that serve as training "laboratories" for participants and as work sites for trained Family Health Care Practitioners. Innovative models for this will be pursued to support the training efforts of both the IOM as well as the NIH.

9. HEALTH ASSESSMENT AND ANALYTIC INSTRUMENTS TO BE USED IN PILOT SITES

9.1. INTRODUCTION

The table below describes health assessments and appraisal of health practices that were identified by the AST team. Data collection for these three assessments had either been completed or was due to start within sixty days of the AST team's arrival. The list is illustrative, not inclusive, of documented health surveys.

Table: Existing Databases and Current Surveys that Determine Health Status and Health Practices in Armenia

Implementer and Database Repository	*Size of Population, Location Surveyed*	*Content of Health Survey*	*Timetable*
National Statistics Service, MOH *Support*: USAID *Contractor*: MACRO	6,500 households (Women 15-49 years: Anemia detection for both women and children, plus, growth charting of all children under 5) 1,300 male respondents *Locations*: Sampled all 9 marzes plus Yerevan	Demographic + Health survey: • Reproductive health, family planning markers • Use of public/private facilities for services • Men's survey re: status of women, gender roles • Use of STD treatment and KAP on AIDS • Anemia measurement in Women 15-49, children under 5 yrs + growth charting of under 5 years • Healthy Lifestyle Risk Appraisal (tobacco/alcohol use)	*Baseline conducted*: Oct. 2000 *Initial Analysis report*: January 2001 (estimated) *Final Report*: customary data tables - December 2001 (est.)
MOH *Support*: USAID *Contractor*: JHU	1,212 households (Married women 18-35 years) *Locations*: Yerevan (500), Lori/Vayots Dzor (apprx. 250 each), Armavir (200+)	Reproductive health, family planning KAP	*Baseline conducted*: May 2000. *1st Analysis report*: January 2001
Gegharkunik Marz Health Department, AIHA, *Support*: USAID *Contractor*: AIHA & National Perinatal Information Center	750 households (Women 18 years & older with children under 10 years) *Locations*: Sevan City & 3 nearby villages	Broad ranging appraisal: Socio-economic well-being, quality-of-life indicators, reproductive health KAP, perceptions of service access, mental health/depression, personal safety perceptions, oral health indicators	*Baseline*: June 2000 *1st Analysis Report*: Aug. 2000

Within 60+ days on either side of the AST start-up, USAID contractors had implemented or were poised to conduct major household surveys, covering about 8,400 family units. The DHS survey comprised a national sample, and the two additional surveys covered three of the five USAID-designated geographic areas for AST interventions (Lori and Gegharkunik Marzes and Yerevan Municipality)**.**

The AST team noted the immediate availability of the above-cited current data assessing health status and utilization of services. Prudent use of resources indicated that no comparable-scale household level survey on health status markers ought to be conducted in the 5 AST-designated work locations.

During the initial mapping of resources, documentation of qualitative research was encountered in the family planning and maternal and child health sub-sectors. (Refer to annexed table of selected qualitative studies on

health practices in Armenia). Further, the AST team contemplates the commissioning of modest scale case studies or other formative research, focused on region-specific health practices as a resource for the development of messages and materials for promotion of healthy behaviors.

9.2. OVERALL ACHIEVEMENTS

1. A tailored AST household survey was designed and initiated in 5 locations, centered on householders' attitudes toward and experience of the use of publicly financed health and social services. The AST team fine-tuned the survey tool so that it focused attention on data related to the utilization of health and social services which had not been investigated by another governmental agency or technical contractor. Since current data on health use and service markers are available from the databases listed in the above chart and other sources, the health section of the AST baseline survey is comprised of only 10 of 67 questions. Consultation was made appropriately about the survey purposes and the instrument with USAID professionals, sector counterparts, donor agencies and related partners.
2. Focused task sessions throughout August-December 2000, and documentation thereof, were conducted in order to agree to AST's access to existing databases on health assessments and health practices drawn from sample populations in the 5 AST-designated intervention areas. Documentation of such agreement is illustrated by the submission here of the minutes of a day-long 26th September 2000 "Retreat" in which the participant agencies were comprised of USAID, AST, AUA (attendees included the President of AUA, School of Public Health faculty and personnel from the Center for Health Services Research).
3. A draft agenda, or checklist, was prepared for suggested AST topics in Qualitative Research on Health Care Practices related to Primary Health Care interest areas. This is a product of cumulative work sessions of the AST team and selected counterparts. During the initial phases of the 5 years ASTP duration, case studies and research methods such as the use of focus group techniques will be used for investigating behavioral aspects of care-seeking patterns in target communities. This will draw upon the services of "known quantity" local organizations and individuals who conduct applied research in the health and social services sectors. These tasks might be conducted by individual researchers working alone, or in tandem with post-graduate students form the Sociology Department of Yerevan State University or the AUA School of Public Health.

9.3. OPPORTUNITIES

The achievements noted in the preceding subsection reflect a number of opportunities identified by the AST team:

1. For the development of a well thought out approach to securing participation in launching the Family Health Care Practice demonstration sites by local civil and health sector authorities, the AST team and partners will be able to draw upon an amalgamation of validated databases which inform the AST partners with indispensable baseline data for planning purposes, e.g., area-specific profiles of family health status, utilization of basic health services and a number of characteristic local practices and behaviors influencing the population's well-being.
2. The AST can make direct contributions to the development of institutional capacity and transfer of know-how to MOH and MOSS counterparts through their hands-on participation in using findings from interpretations the above-cited databases for decision-making. The cited information sources will provide inputs for future work to be done under the MOH's Strategy for the Optimization of Health Resources and the establishment of Family Health Care Practices in designated marzes and Yerevan City.

9.4. BARRIERS

Coordination of parallel activities by several stakeholders under the development of Family Health Care Practice Sites will prove a challenge. The training and placement of Family Medicine trained physicians financed by a World Bank loan has completed its first cycle. The AST team must join a large, but not necessarily well-coordinated, number of activities already launched by the MOH, the World Bank, and other donors since 1997. Many elements of the momentum created appear to have a sound basis. Others merit review and modification, such as the formulation and implementation of a less-than-complete curricular approach at the National Institute of Health, to the training of post-graduate doctors and nurses. Family Medicine experts

find these training programs to be almost totally lacking in a clinical practice approach. The Director of the NIH Training Program for Family Medicine teams has shown himself to be particularly unreceptive to collaborating with the AST team.

9.5. THE NEXT SIX MONTHS

Data analysis of the AST baseline survey data ought to be completed during early part of 2001. This picture of respondents' perceptions about access to and experience with the delivery of health and social sector services can be fitted together during 2001 with the above-cited USAID-financed databases to form an emerging profile, specific to the 5 AST locations, of health status indicators and unmet needs for services. The AST team will make ample use of these information sources in advising national and local health authorities. Examples of this include implementing strategies of Optimization of Ministry of Health resources as well as the appraisal work needed to implement optimization at the local level.

10. ASSESSMENT OF CAPACITY OF REGIONAL NGOS

10.1. INTRODUCTION

The AST has only begun the process of identifying NGOs that may participate in the pilot project in Lori Marz. In the coming two months, the AST will develop a plan for NGO development that embodies two components: 1) establishing a legal framework at the national level; and 2) incorporating local NGOs i the activities to be conducted in the pilot sites.

10.2. ACHIEVEMENTS IN ASSESSMENT OF CAPACITY OF REGIONAL NGOS

The AST team has identified the following international NGOs active in the Lori Marz:

Armenian Assembly of America: NGO Training and Resource Center (NGOC) which is intended to strengthen capacity of local NGOs providing social or primary health care information and services.

Adventist Development and Relief Agency (ADRA): Lead PVO for " Network for Health" project to improve RH/FP/CS/HIV/AIDS knowledge and practices in Armenia.

Catholic Relief Services (CRS): Sustainable social and health education to school children, short term job opportunities, integrated model for school feeding, school canteen rehabilitation, water and sanitation improvements.

Save the Children Foundation (SC): Creating short-term employment and/or income generation opportunities through public work projects, ensuring the input of and participation of women, selection and community appointment of local management committees.

United Methodist Committee on Relief (UMCOR): Integrated school feeding, public works, NGO capacity building projects for social/health NGOs, will work closely with PADCO to establish a data management system to ensure the transparency and accountability, to improve communication and experience sharing, and to endorse the public awareness of health and social services. UMCOR also manages Noah's Ark Food Security program to provide food security and generate income -- supported by the Heifer Project Int. (HPI), and soup kitchens.

The AST team has identified the following international NGOs active in the Lori Marz:

Young Men's Christian Association (YMCA) (Suren Mardirossian, President) Training in social ethics, leadership, volunteering, computer literacy, social advocacy, arranging meetings, seminars etc.

Women's Voluntary Organization (Melania Mirzoyan, President) Involved in all aspects of women's issues, single mothers, vulnerable families

Aragast Social Agency (Koryun Shekoyan, Chairman) Currently, working for the welfare of invalids, skills and physical training.

PEACE CORPS VOLUNTEERS (Community Health Education)

10.3. NEXT SIX MONTHS

AST's implementing partner Counterpart will develop and NGO workplan and begin working with individual NGOs in the pilot sites

11. THE DEVELOPMENT OF A PERSONIFIED REPORTING SYSTEM FOR THE SIF

11.1. INTRODUCTION

Social insurance systems require the creation and maintenance of very large databases of covered individuals that must be constantly updated. These databases are the way in which revenues are collected from covered individuals (or, on behalf of beneficiaries, by employers). It is also the way that eligibility for benefits is determined and records maintained of benefit payments. Today, Armenia lacks these databases. The Social Insurance Fund – which collects payments from enterprises and registered entrepreneurs – maintains no individual reports of those individuals covered by the state old age pension insurance, invalid and workers compensation insurance, unemployment insurance, and other social insurance (maternity benefits etc.). The result is that it cannot operate as a proper social insurance fund.

Any health insurance program depends on the ability to collect contributions from the covered members of the workforce, to manage the funds collected, and to maintain databases on the allocation of health insurance benefits. The first two functions will be the responsibility of the SIF (in collaboration with the MOSS Information and Analysis Center) – whatever agency is ultimately assigned the responsibility for managing the health insurance system. There is nothing to gain from the creation of a third tax collector (after the Ministry of State Revenues and the SIF) to manage revenue collection for the health insurance system. The revenues and databases collected and compiled by the SIF may be transferred to the health insurance agency (or constituted as a separate fund within the health insurance fund, administering the distribution of benefit payments according to the rules and regulations promulgated by the MOH).

Health insurance reform, therefore, depends on creating a system of personified reporting by enterprises and other legal entities and the creation of a central database in the Social Insurance Fund that maintains records of the work history and wages of all working people in Armenia. This database is vital in establishing the eligibility for and level of benefits for those covered by social insurance programs. This system will be managed through the MOSS Information and Analysis Center. A schematic representation of this system and its connection to the Ministry of Health is provided below.

11.2. OVERALL ACHIEVEMENTS

The AST can report the following achievements in the area of the development of personified reporting systems to support social insurance systems:

1. The AST organized and conducted an observational tour, from November 12 to November 18, for 12 technical specialists from the SIF and the MOSS to Moscow to examine the experience of the Social Insurance Fund of the Russian Federation in creating a personified reporting system.
2. The AST is negotiating a detailed workplan with MOSS and the SIF for collaboration with the AST to implement a personified reporting system.
3. The AST has completed a detailed analysis of the reporting requirements and the data storage systems of the SIF (see Attachment). Based on this analysis the AST is now preparing draft rules and regulations to implement the new personified reporting system.

11.3. OVERALL OPPORTUNITIES

The AST team believes that the rapid implementation of the personified reporting and record keeping system will be possible because:

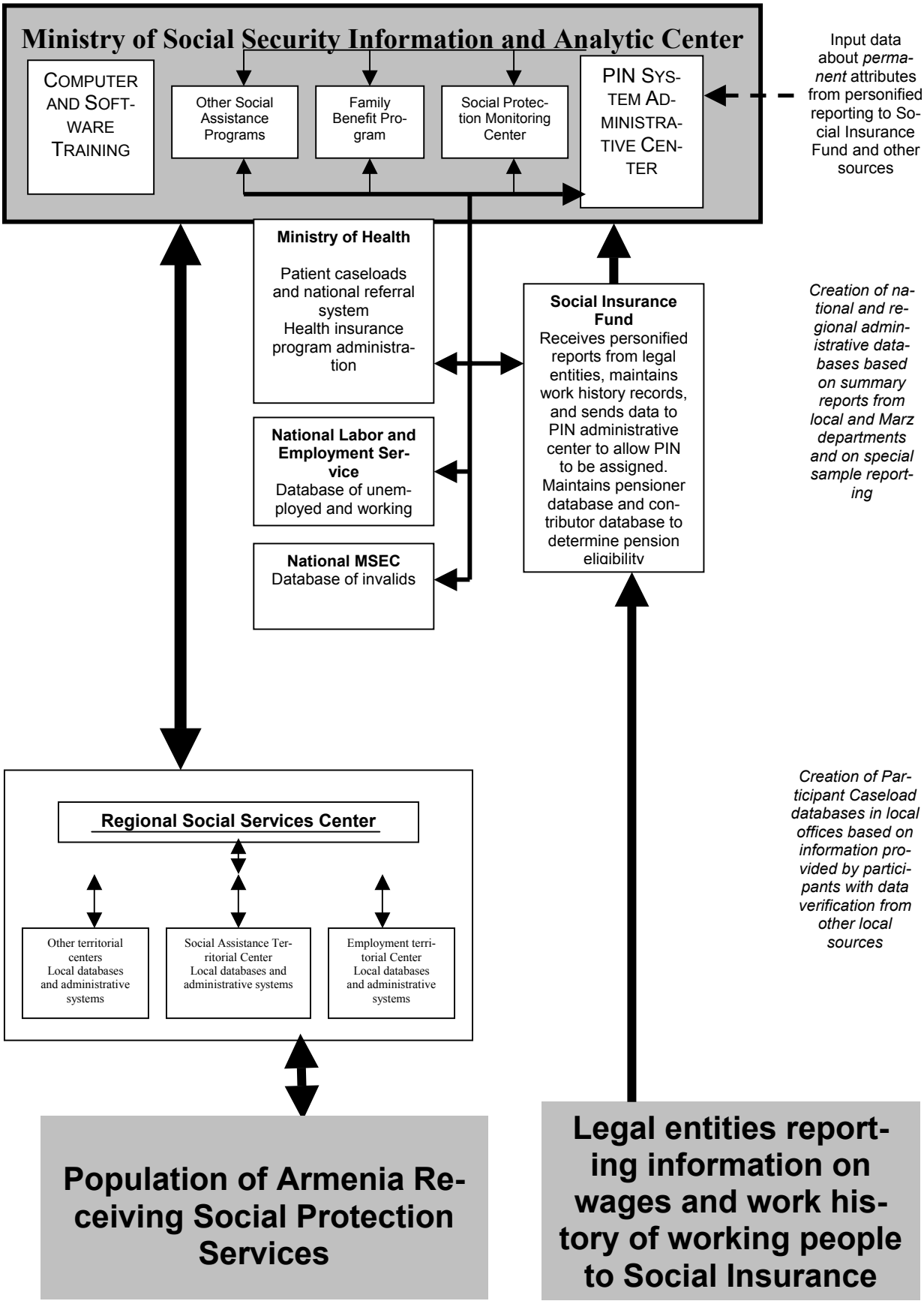
1. The MOSS and SIF are now aware of what is involved in creating a personified reporting and record keeping system and are willing to proceed with its implementation
2. The Mergelyan Institute (formally the Yerevan Institute for Computer Research and Development) has already developed a large part of the software that will be needed to create the personified record keeping system.
3. PADCO has already developed and implemented a personified reporting system in Ukraine that can be transferred easily to Armenia.
4. No other donors are involved in the issue, allowing easier collaboration with counterparts.

11.4. BARRIERS TO PERSONIFICATION OF SOCIAL INSURANCE SYSTEMS

The AST team has identified no significant barriers to overcome to move forward effectively in the area of personification. Nevertheless, the AST anticipates that, as fast as the GOA develops trained specialists in computer software design and development and in database management, they will be quickly attracted away to the private sector because of the chronically low wages paid to government employees. The problem is being temporarily resolved by MOSS and SIF by the use of World Bank credits to pay computer specialists at rates four or five times the monthly wage earned by other ministry employees of comparable rank. But this is not a sustainable approach. MOSS is investigating the possibility of creating new pay scales over the next two years as a solution to the problem.

11.5. THE NEXT SIX MONTHS

Within the next six months, the AST team is confident that significant steps will have been completed toward beginning the process of personification. The task of personifying reporting and building the necessary database is estimated to take two years – based on the experience in Russia and Ukraine.


Ministry of Social Security Information and Analytic Center
COMPUTER AND SOFTWARE TRAINING
Other Social Assistance Programs
Family Benefit Program
Social Protection Monitoring Center
PIN SYSTEM ADMINISTRATIVE CENTER
Input data about permanent attributes from personified reporting to Social Insurance Fund and other sources
Ministry of Health
Patient caseloads and national referral system
Health insurance program administration
Social Insurance Fund
Receives personified reports from legal entities, maintains work history records, and sends data to PIN administrative center to allow PIN to be assigned. Maintains pensioner database and contributor database to determine pension eligibility
Creation of national and regional administrative databases based on summary reports from local and Marz departments and on special sample reporting
National Labor and Employment Service
Database of unemployed and working
National MSEC
Database of invalids
Regional Social Services Center
Other territorial centers
Local databases and administrative systems
Social Assistance Territorial Center
Local databases and administrative systems
Employment territorial Center
Local databases and administrative systems
Creation of Participant Caseload databases in local offices based on information provided by participants with data verification from other local sources
Population of Armenia Receiving Social Protection Services
Legal entities reporting information on wages and work history of working people to Social Insurance

12. CREATING MIS SYSTEMS TO SUPPORT REFORMS IN HEALTH LICENSING PROCEDURES

12.1. INTRODUCTION

The Ministry of Health is responsible for licensing health care facilities and health care practitioners. The licensing of health care facilities is conducted within the National Institute for Health (NIH), which must maintain information about the activities of over 700 health care facilities throughout Armenia. These facilities are required to complete reports every quarter, but managing this paper flow is beyond their present capacity. The AST will develop and strengthen this capacity.

The Government of Armenia adopted a resolution "On the Licensing of the Medical and Pharmaceutical Activities in the Republic of Armenia" in 1996. All medical institutions and their professional staff, and all medium-level medical personnel (physicians, medical chemists, medium-level medical workers and pharmacists) wishing to undertake independent activity in specialized areas of medical practice, were subject to licensing by the Ministry of Health (MOH). After the initial licensing, the license issued must be reconfirmed once every five years. During this period, the medical worker had to pass a minimum course of post-diploma professional training (training, improving the qualification, lectures, seminars, etc.), which must be corroborated by the state as a minimum standard for licensing. The medical worker or the medical institution can undertake only the type and the volume of the medical activity that is specified in the license. Medical activity without a license, or over and above the framework of the license, was prohibited. The licenses are provided by a licensing service that is organized as an independent operating unit out of the structure of the MOH and under the direct administrative control of the National Institute of Health (NIH).

Activities of the licensing service are subject to the state governing structures, according to the legislation of the Republic of Armenia. These include, in addition to the MOH, the Central Licensing Commission (CLC) which is the supreme body overseeing the licensing service. The CLC president and members are elected by health administrating structures, medical institutions, professional medical associations, medical insurance societies, trade unions of medical workers, and public organizations representing the interests of patients. CLC sub-groups, Branch Licensing Commissions (BLC) are formed by representatives of professional associations. These sub-groups are responsible for the licensing of specialized categories of medical workers and health care institutions.

The NIH Licensing Office (LO) is responsible for the administrative, technical, and financial management of Armenia's health licensing service. The LO is also the state registry for medical licensing. According to LO information, there exists a database with the names of 9400 Doctors and 2000 nurses already licensed. Besides this number, the names of 11600 Doctors, 7400 Nurses, 870 *Provisors* (suppliers of drug stores) and 849 Pharmacists are to be included in the database.

12.1.1. Health Professional Licensing Procedures

There are 82 different health professional specialties for which computerized exams are given and licenses are awarded. Licensing procedures are as follows:

First time license applicants seeking a primary license present the LO with documents required by the NIH.

Upon receipt of the applicant's documents, LO checks their compliance with established requirements, and either accepts them or returns them to the applicant. Within 10 days after accepting an applicants documents, the LO administers a computer test approved by the MOH. If the license applicant answers correctly 50% of 100 questions during a one-hour testing period, NIH awards a "pass" evaluation. The results of the test is filed in the individual's licensing register.

When an applicant has passed the computer exam, the result it is transmitted to the corresponding BLC which then schedules an oral professional interview with the applicant within 10 days of receiving the test results. If the applicant passes the oral interview, and the Minister of Health approves, the LO gives the applicant a license signed by the Minister and confirmed with the seal of the MOH.

12.1.2. Licensing Office

The LO currently reports to both the MOH and the NIH. Administratively and financially it reports to the Director of the NIH. All the Commissions are appointed from the MOH and final approval of licenses is made by the MOH. The LO staff includes: Director; Administrative Assistant; Head of Licensing Department; 4 Curators; Head of Computer Department; testing specialist; administrative assistant; secretary; registrar (see below).

12.1.3. MOH Request for Assistance

To improve current operations of the Licensing Office (LO), MOH requested the assistance of the AST. AST's first response was to form a working group to:

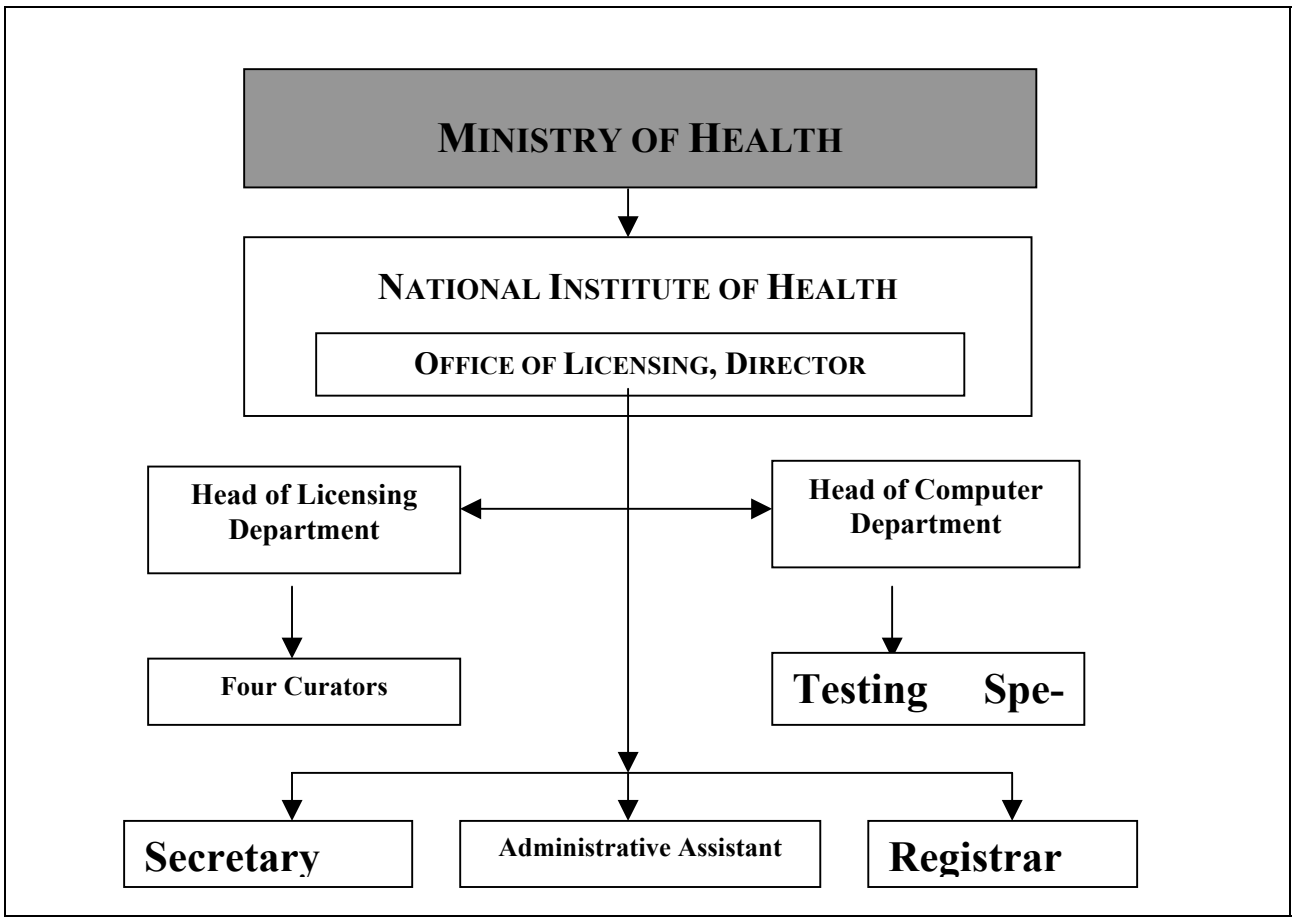
- Assist MOH and NIH to reform licensing programs by improving licensing standards and estimating criteria, as well as improving computerized licensing examinations.
- Assist the LO staff to implement an improved licensing system based on decisions by MOH and NIH, informed by an assessment of international licensing procedures and standards and on study tours focused upon health professional licensing.
- Assist in the procurement of information technology (IT) hardware and software.
- Assist in the linking of licensing with the continuing education of specialists.

There are three major components of AST licensing activities:

1. The computer system (software and hardware);
2. The content of the computerized licensing examinations; and
3. The correlation of licensing with education and performance.

The first phase is to assess current licensing software and hardware, and determine what is needed to improve and update the system:

- Assess how well current software works;
- Analyze programming language and source codes;
- Determine desired changes in functions;



- Assess applicability of "off the shelf" software; and
- Assess the best method to obtain better software.

The estimated time for the completion of this assessment is 3 months. Once the assessment is completed and improvements determined, a work schedule would be prepared for upgrading software and procuring and installing computer equipment to support it. Decisions on the content of an upgraded testing system must be agreed upon by the MOH and NIH. These decisions include:

- Questions to be added to the current list;
- Questions to be deleted from the current list;
- Languages and format to be used; and
- Who determines future changes in test questions.

Once this work is completed, new or improved software can be developed. This can be done at the same time as assessment are conducted, so that software can be developed in a timely manner. With the design of a relational database, much useful information can be made available to MOH and NIH. The name of the license applicant can be linked to:

- The score on the examination;
- The place of work and educational qualifications;
- Supplementary courses completed; and
- Medical practitioner performance reviews, wage awards, honors

Correct and incorrect answers can be analyzed by MOH and NIH to determine what areas of education should be enhanced or emphasized for medical practitioners. A database of licensed medical professionals (currently, there is an incomplete list of licensees, not in a data base) could be used for a variety of purposes. Once work on enhanced software begins, a relational data base can also be developed and installed on new computers at both MOH and NIS dedicated to this information.

An enhanced health professional licensing system can address not only the immediate concerns of the MOH and NIH for improved computer tests, but also introduce computerized relational databases to enable those managing health care in Armenia to analyze data for many different purposes related to quality control.

12.2. ACHIEVEMENTS

The AST has begun assessing the MOS needs in the licensing process. The outline of NIH Health Professional Licensing Activities is being conducted according to the following workplan:

1. Assessment of organization
    a. Organization chart
    b. Number of employees
    c. Job descriptions/responsibilities
    d. Staff with computer skills
    e. Availability of additional space for training facility, database
2. Description of what MOH wants
    a. New testing software
    b. New testing computer network
    c. Separation of study and test administration
3. Description of what NIH wants
    a. New testing software
    b. New testing computer network
    c. Four computers for testing specialists
    d. Database of licensees
4. Assessment of software
    a. Written in what language?

   b. Who has source code
   c. Size of files?
   d. Capabilities for change
   e. What it now does
   f. What NIH would like it to do
   g. What MOH would like it to do
   h. List of people/companies capable of revising software
   i. Internet search of current licensing software
   j. Recommendations on modifying old software or buying new
5. Assessment of computer needs
   a. What computers are being used for licensing?
   b. What is their capacity?
   c. What is the server's capacity?
   d. What is required by current software/usage?
   e. What is required by revised or new software?
6. Draft specifications for new licensing software
7. Draft work plan for programming and testing activities
   a. Purchasing of or contracting for software
   b. Programming of software to meet NIH requirements
   c. Debugging and testing of software
8. Draft procurement plan for new computer technology
9. Draft job description(s) for computer systems administration
   a. Specifications of job requirements
   b. Determination of training needs
10. Site preparation for new testing computers
   a. Determination of facility renovation needs
   b. Contracting for renovation
   c. Renovation work
11. Installation of new software
12. Training in new software use
13. Preparation of testing procedures manual
14. Evaluation of capacity of current computers to be used for training
   a. Assessment of condition and capacity of current computers
   b. Renovation of old or procurement of new computers
15. Site preparation for training in taking computer test
   a. Selection of training facility
   b. Determination of renovation needs
   c. Contracting for renovations
   d. Renovation work
16. Preparation of training procedures manual
17. Assessment of hardware and software needs for NIH specialists
18. Procurement of specialists' hardware and software
19. Site preparation for specialists
   a. Determination of facility renovation needs

   b. Contracting for renovation
   c. Renovation work
20. Training for specialists in hardware and software use
21. Assessment of licensee database software and hardware needs
22. Purchase of and programming of relational data base
23. Site preparation for licensee database in NIH and MOH
24. Purchase of computers and communication links between NIH and MOH
25. Training of database staff

12.3. THE NEXT SIX MONTHS

During the next six months, the AST team will implement the workplan described in the preceding section.

13. THE DESIGN AND IMPLEMENTATION OF THE PIN SYSTEM

13.1. INTRODUCTION

The PIN system has been recognized by the Government of Armenia as a key element in maintaining administrative databases for social protection, social insurance, health, and other programs maintained by a variety of different ministries. The SIF, for example, anticipates use of the PIN system to order to maintain personified work histories of all working Armenians. The Ministry of State Revenues anticipates use of the PIN system for more effectively managing tax records of individuals registered as entrepreneurs or registered as holding more than one job. An integrated social protection database allows for the appropriate exchange of relevant data among different ministries and between local, Marz, and central government offices. For example, under the existing PAROS methodology for determining eligibility for family benefits, the Ministry of Social Security must compare the data supplied by households applying for assistance with information on electricity billing, payment of customs duties for imported goods, automobile registration data, pensioner benefits paid to individuals, and the civil registry (births, deaths, and marriages).

The PIN system will greatly facilitate the exchange of information among different databases. Unlike names, addresses, and other individual characteristics of families and individuals, the PIN does not change during an individual's lifetime. But the exchange of information among ministries and between national and local databases requires the development of protocols to ensure the sharing of the right information including the prevention of misuse of information and the protection of the privacy of individuals.

Chart: Age of Person and Nexus to Social Protection System

Infant	*Child*	*Schoolchild*	*Student, Young worker*	*Working Adult*	*Pensioner*
Birth to 1 year	*1 to 5 years*	*5 to 16 years*	*16 - 21*	*21 –60 (man)*	*60+*
		Ministry of Education			
				Individual Insurance (Health, pension, etc)	
					Social Insurance Fund
			Unemployment Department		
			Tax Department		
		Passport Department			
Civil Status Registry Offices	**Civil Status Registry Archives**				
Targeted Social Assistance (Family Benefits) System					
Health Care System					

For health programs, the PIN system will be an important factor in:

- Implementing and managing a national health insurance system
- Targeting special health benefits to needy populations
- Creating a nationwide patient caseload referral system
- Ensuring closer coordination between social assistance programs and health programs

In this workplan, the Ministry of Social Security and PADCO outline their collaborative activities that will be undertaken between November 15, 2000 and November 15, 2001 to fulfill the first stage of these mutual objectives. The tasks will be reviewed at the end of this workplan period and will form the basis for further collaboration in the future. The collaboration between the Ministry of Social Security and PADCO during the first year will focus on three principal activities: 1) the creation and support of an information center within the Ministry of Social Security, described in the following section of this workplan; 2) support for the work of the PIN Implementation Board created by order of the Minister of Social Security to manage the in-

troduction and administration of the PIN system (described in the subsequent section of this workplan); and 3) the transfer of the databases and administrative capacities for the PAROS database and the Family Benefits Program from the Mergelyan Institute to the Information Center (see following task specific workplan).

The Ministry of Social Security is creating an Information and Analysis Center that will serve multiple purposes in the realization of the Ministry's plans to create more efficient and effective administrative and management systems for social assistance and social insurance programs. A central task for the new center will be the implementation and administration of the PIN system.

13.2. ACHIEVEMENTS IN PIN IMPLEMENTATION

The AST can report the following achievements in PIN implementation:

1. The AST has successfully negotiated an agreement with the PIN Implementation Board and has already begun to implement this agreement. The AST will support the PIN Implementation Board created by the GOA in September 2000 in providing material and technical support (see Attachment 1, below).
2. The AST has provided the PIN Board with a concept paper and draft legal recommendations on a law to protect privacy of information. Enactment of this law is a pre-requisite of the implementation of the PIN system.
3. The AST is creating an Information Center for the MOSS, which will house the PIN administrative unit (as well as other social protection MIS, database management, and administrative functions) – leveraging $100,000 in equipment financed through a World Bank credit.
4. The AST has negotiated a workplan for the implementation of the PIN system that has been adopted by MOSS and the PIN Implementation Board as the basis for further work in PIN implementation.

13.3. OVERALL OPPORTUNITIES

The AST team believes that the rapid implementation of the personified reporting and record keeping system will be possible because:

1. The MOSS and SIF are now aware of what is involved in creating the PIN system and have overcome initial opposition on the allocation of responsibilities.
2. Work under the previous TACIS project and by The Mergelyan Institute (formally the Yerevan Institute from Computer Research and Development) has laid the groundwork for resolving many issues related to PIN implementation.
3. The World Bank is providing material and technical assistance in PIN implementation and is openly collaborating on this issue.
4. The Minister of Social Security is aware of the importance of public education in ensuring the adoption of the necessary enabling legislation and in gaining public acceptance for the PIN system.

13.4. BARRIERS TO PIN IMPLEMENTATION

PIN implementation is an enormously complex task. The full complexity has not yet been realized by the PIN Board – and is poorly understood even by those ministries and agencies that will be directly involved in its implementation. There are also fears among several key policymakers that the PIN is an intrusive, privacy threatening program.

There are also many design and implementation issues to be resolved and many collateral reporting systems need to be developed before PINs can be assigned to the entire population. The full extent of the cost of implementing the system has still to be accurately calculated – and may extend beyond the $1.5 million originally estimated by the PIN study, from which the AST budget allocation was based.

13.5. THE NEXT SIX MONTHS

Within the next six months, the AST team is confident that significant steps will have been completed toward beginning PIN implementation. In addition to technical support on legal drafting and software system design and the creation of the Information Center, the AST will be involved in working with the PIN board to design and begin implementation of a public education campaign to assuage fears about the intrusive nature of the PIN.

The workplan prepared for the PIN Implementation Board by the AST team is shown in the table below:

ACTIVITY SCHEDULE FOR PIN IMPLEMENTATION: DECEMBER 2000 – DECEMBER 2001	
Activity	***Date Completed***
1. Develop workplan and implementation schedule for PIN Implementation embodying PIN Concept paper and Information Flow Concept	December 31, 2000
2. PIN Implementation Law	
Prepare detailed outline of structure of PIN Implementation Law	December 31, 2000
Prepare draft of PIN Implementation Law	March 15, 2001
Review and respond to all comments on draft	April 15, 2001
Submit draft law for approval to Government	May 1, 2001
3. Law on Information and Privacy Protection	
Prepare comments and recommendations on draft of law on Information and Privacy Protection	**December 31, 2000**
Draft Information and Privacy Protection Law submitted to Government for approval	May 1, 2001
4. Prepare comments and recommendations on workplan for implementation of personified reporting system for Social Insurance Fund	January 31. 2001
5. Prepare schedule for sequencing of assignments of PIN numbers based on personified SIF database	March 2001
6. PIN Assignment Software:	
Prepare specifications for design of PIN assignment software	February 15, 2001
Prepare staffing plan for design, development, and testing of PIN assignment software	**February 15, 2001**
Test modules of PIN assignment software as completed by design team	April – Sept 2001
PIN assignment software ready for implementation	Sept 2001
7. Creation of Central PIN database	
Prepare specifications for design of PIN database and updating procedures	**February 15, 2001**
Prepare staffing plan for design, development and testing of PIN database and updating procedures	February 15, 2001
Test modules of PIN database software as completed by design team	April – Sept 2001
PIN database software ready for implementation	Sept 2001
8. Develop methodology for detection and elimination of PIN duplication and identification and correction of database errors	June 30, 2001
9. Prepare draft of instructions for establishing of pilot sites for testing procedures for assignment of PIN numbers and testing communications between Information Center and local offices	March 31, 2001
Test PIN assignment software and updating procedures in pilot sites	Aug – Dec 2001
10. Prepare nationwide communications plan for connecting Information Center with local social protection and other offices (including specifications for responsibilities of staff from SSIFs, RSSCs, RSELs, and other offices)	April 30, 2001
Test communications systems in pilot sites	Sept – Dec 2001
11. Develop draft instructions for all agencies and local offices involved in PIN implementation	June 30, 2001

ACTIVITY SCHEDULE FOR PIN IMPLEMENTATION: DECEMBER 2000 – DECEMBER 2001	
Prepare manual and training plan on PIN responsibilities for staff of local offices involved in PIN system (including RSSCs, SSIFs, etc)	Oct 31, 2001
12. Prepare manual for PIN system administration in Information Center	July 31, 2001
Prepare training plan for existing PIN Center staff and long term plan for skills updating and training of new staff	July 31, 2001
13. Prepare specifications for design of protocols for sharing PIN numbers among all users within Government of Armenia	September 30, 2001
14. Prepare public education campaign to explain purpose and operations of PIN system – using TV, radio and other media	August 31, 2001

To support the work of the PIN Implementation Board in designing and implementing the PIN system, PADCO will provide the following material and technical support:

Material Assistance
1 desktop computer for the PIN Board to use for management of the implementation process
1 small copier
1 plain paper FAX
E-mail and internet connection for 12 months
An installation and monthly updating of a legal database of laws of Armenia
A library of laws of other countries related to PIN systems, Information Privacy, and other issues, translated into Armenian
Technical Support
Support from up to three lawyers as well as international experts for the drafting of laws and other normative acts related to the implementation of the PIN system. These laws and normative acts shall include a draft law for the protection of the privacy of information maintained on social sector databases, a law defining the PIN system, and the normative acts necessary to allow the sharing of data among different ministries. After an initial assessment, the technical assistance may also include some public information activities, which would introduce the concept of personified information to improve social targeting without intruding on the individual right of privacy guaranteed by the Armenian constitution and democratic principles.
Support from up to three computer programmers and international MIS experts in designing and developing database systems, data exchange systems, data protection procedures, and other tasks necessary for the realization of the PIN system in Armenia.
Support as needed from computer technical specialists in the installation and utilization of the equipment to be installed in the PIN administrative section of the Information Center.
Support as requested for the translation of laws, reports and other materials into Armenian to ensure that the PIN Board and its consultants have access to relevant models and information for the implementation of the PIN system

14. BASELINE SURVEY OF PUBLIC USE OF AND ATTITUDES TOWARD HEALTH AND SOCIAL SERVICES

14.1. INTRODUCTION

PADCO is conducting a survey of about 1,000 families. This will be a panel survey – the same families will be interviewed every 6 months by a team of survey specialists from Yerevan State University. The sample will be selected from the populations of the five pilot Marzes – Yerevan, Shirak, Lory, Gegharkunik, and Syunik -- with the sample concentrated in the pilot communities within these Marzes. The survey is intended to provide a profile of changes over time in public attitudes toward, knowledge of, and use of social and health services. These changes over time would reflect the impacts of project activities that lead to reforms in social protection policies at the national level and activities in the proposed pilot sites. Survey results will supplement information obtained from many different sources during the implementation of the AST program.

The purposes served by this survey are:

- Measure indicators for USAID monitoring of SO 3.4;
- Measure indicators of specific project activities related to outcomes under the AST contract;
- Guide the AST program team in management of project activities (such as public education, public outreach, etc); and
- Provide Government of Armenia (GOA) policymakers – through a regularly published statistical bulletin based on survey results -- with a clear and comprehensible set of indicators to inform the policymaking process. The survey is intended, in part, to be replicable "consumer satisfaction survey" for managers and administrators of social protection programs.

Because the survey focuses on changes over time, it is designed as a "panel" survey – allowing the regular interviewing and re-interviewing of the same sample of families. There will be two survey instruments:

The Baseline Survey: This will compile socioeconomic and demographic information about the participating households, data about their knowledge, access, and use of social and health services, and data about their attitudes toward the quality, perceived fairness, how they rate their socio-economic situation and other aspects of the services used.

Follow-Up Surveys: The subsequent surveys –conducted every six months (see below) -- will include two parts:

The first part will include questions allowing for updates on answers to questions posed in the baseline survey: how has family composition changed? How have family economic circumstances changed? What social and health services have been used within the last six months? And how have family attitudes toward and perceptions of social and health services changed during the past six months?

The second part of the follow-up surveys will include questions related to specific recent interventions. For example, after changes have been made in the procedures for registering for the Family Benefit Program or in the formula for calculating benefits, families will be asked specific questions about their views on this recent intervention. There are a series of major interventions that will be the focus for these "special" survey questions. These include: changes in the family benefit registration and benefit calculation procedures, the implementation of appeals and audit systems for the family benefit program, the restructuring of local health care facilities, the creation of family practice centers, reforms in old age and invalid insurance programs, consolidation of RSSCs, the implementation of special outreach programs, etc.

It is intended to use the results of the first part of the follow-up survey to prepare regular reports showing how circumstances and attitudes of families have changed. This may be done by designing the questionnaire in a format that allows the data to be scanned into a computer database and designing a "template" that allows the rapid preparation of a standard series of tables and figures that presents the dynamics of changes over time. These standard tables and figures will be used as the basis for preparing a regular report.

14.2. ACHIEVEMENTS OF THE SURVEY

The survey will be completed by December 31 and the results available for analysis by January 15, 2001. The survey includes the following questions related to health services:

C. HEALTH INFORMATION

C.1. During the last 12 months, did you or a member of your family experience a personal medical problem?

C.1.1 Yes

C.1.2 No----------→ ***Go to C.8***

C.1.3 Don't know--------→ ***Go to C.8***

C.2 Did you or a member of your family visit a medical professional for the last such problem?

C.2.1 Yes----------→ ***Go to C.4***

C.2.2 No

C.3 What is the reason that you did not see a medical professional?

INTERVIEWER: Circle all responses that apply.

C.3.1 Lack of money

C.3.2 Lack of transportation

C.3.3 Too far

C.3.4 Lack of time

C.3.5 Religious opposition

C.3.6 Family objections

C.3.7 Don't know where to go

C.3.8 Did not want to go alone

C.3.9 Don't have female doctors

C.3.10 Don't trust doctors

C.3.11 Other (specify)

C.3.12 Don't know

Go to C.8

C.4 At that time did you visit a health care facility?

C.4.1 Yes ----------→ ***Go to C.6***

C.4.2 No

C.5. Why didn't you visit a health care facility to seek medical help?

INTERVIEWER: Probe respondent and estimate answer. Circle all responses that apply.

C.5.1. Problem was relatively minor

C.5.2. Don't like to go to the health care facility

C.5.3 Health care facility does not provide sufficient care and services

C.5.4 Going to a health care hospital is too expensive

C.5.5 No trained doctors available at the hospital

C.5.6 Lack of transportation

C.5.7 Too far

C.5.8 Family objections

C.5.9 Other reason (specify)

Go to C.8

C.6 At which health care facility did you seek advice or treatment?

C.6.1 Public sector hospital ----------→ ***Go to C.8***

C.6.2 Public sector polyclinic----------→ ***Go to C.8***

C.6.3 Public sector pharmacy----------→ ***Go to C.8***

C.6.4 Other public facility----------→ ***Go to C.8***

C.6.5 Private hospital/facility

C.6.6 Private pharmacy

C.6.7 Private doctor
C.6.8 Other private
C.6.9 Other (specify)

C.7. Why didn't you visit a government health care facility?

INTERVIEWER: Circle all choices below that apply

C.7.1. Do not trust a government health care facility-----→***INTERVIEWER: Probe further***
C.7.2. Past experience has been bad
C.7.3. Cannot choose my doctor
C.7.4. No capable doctors available
C.7.5. Facilities are not well equipped
C.7.6. Facilities not clean
C.7.7. Waiting lines are too long
C.7.8. Expensive
C.7.9. Other (specify)
C.7.10. Don't know

C.8. Do you agree with the following statement?

INTERVIEWER: Read the following statement aloud.

"I am very satisfied with the medical care that my family receives at the polyclinic/ambulatory clinic/FAP."

C.8.1. I strongly disagree
C.8.2 I disagree
C.8.3 I am not sure
C.8.4 I agree
C.8.5 I strongly agree
C.8.6 Don't know

C.9 What do you think about the general health of your household?

C.9.1. Excellent
C.9.2. Very good
C.9.3. Good
C.9.4. Fair
C.9.5. Poor

C.10 Briefly, do you have any suggestions on how the health care system can be improved?

INTERVIEWER: Limit the comments to a maximum of three lines.

_____
_____
_____

14.3. THE NEXT SIX MONTHS

By January 31, 001, the results of the baseline survey will be completed. The AST team will then begin work on the follow on survey that may be used to focus on more detailed aspects of the health system. The regular reports from the survey will be reported through the MOSS Information and Analysis Center to provide important information for the public education component of the AST.